

Progressive Child & Adolescent Gastroenterology

Date: _____

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**Welcome to Pediatric Gastroenterology
Second Opinion Consultation Questionnaire**

Patient Name: _____ **D.O.B:** _____ **Sex:** M F **Person filling out this form:** _____
Relationship: _____ **Home or Cell Phone number:** _____ **Pediatrician:** _____
Referred by: MD ER Online Friend/Family Other: _____ **Previous GI specialist(s):** _____
How long has this been a problem? 2 weeks 1-2 month 3-4 month 5-7 months 10-12 months Other: _____
Symptom/Condition for which second opinion is being sought: _____
List 2 main concerns: _____
List 2 main expectations: _____
Other associated symptoms: _____

Please list current medications (including OTC medications, vitamins, herbal remedies, birth control & holistic supplements):

Name	Dose/Strength	How often?	Start Date

Does your child have any known allergies? No Yes (If yes, indicate below)

Allergy	Name of Food or Medication	What was the reaction?
Drugs <input type="checkbox"/> No <input type="checkbox"/> Yes		
Foods <input type="checkbox"/> No <input type="checkbox"/> Yes		

Past Medical History (Check all that apply): None significant

GI: GERD Constipation Pyloric Stenosis Diarrhea Excessive weight gain Other _____

Heart: Murmur Palpitations Vasovagal attacks Chest pain Other _____

Lung: Pneumonia Bronchiolitis Aspiration Pneumonia Apnea Asthma Other _____

Musculoskeletal: Lupus Juvenile Rheumatoid Arthritis Ehlers-Danlos Muscular dystrophy Other _____

Neuro: Seizure disorder Cerebral Palsy Autism/Asperger's Meningitis Other _____

Psych: Anxiety Depression ADD ADHD ODD Bipolar disorder Other _____

Endocrine: Diabetes Hypothyroidism Failure to thrive GH deficiency Other _____

Other (if any, please specify) _____

Past Surgical History (Check all that apply): None

Appendectomy Inguinal hernia repair Umbilical Hernia Repair Tympanostomy Tonsillectomy Adenoidectomy

Lacrimal duct dilation Cholecystectomy Congenital heart repair Other (specify) _____

Immunization History of your child: Up to date Delayed Withheld (please indicate reason): Medical Personal

Pregnancy History: Indicate # of pregnancy: 1st 2nd 3rd Other _____

Were there any complications during pregnancy in the mother? No Yes (Please check all that apply)

Gestational Diabetes Low amniotic fluid Polyhydramnios Pre-eclampsia Hyperemesis Gravidarum Pre-term contraction Other _____

Birth History: Full-term Premature Estimated gestational age in weeks: _____

How was the baby delivered? Vaginal Vacuum/forceps assist Cesarean (Please indicate reason _____)

Baby's birth weight _____ **lb.** _____ **oz.** **Were there any complications with your baby at birth?** No Yes

If yes, please check all that apply: Meconium aspiration Breathing difficulty Ventilator Use Feeding difficulties

Jaundice Other (please specify) _____

Was your baby in the NICU? No Yes If yes, how long? _____

What was the main diagnosis? _____ What was the treatment? _____

When did your baby have the first bowel movement (meconium)? 24-48hrs 48-72hrs Greater than 72 hrs Not sure

Were any interventions needed? No Yes If yes, what was it? Rectal tube Suppository

Family history: Check the box and list the relationship to the patient next to the condition. Childhood death Cirrhosis

Celiac disease Crohn's Disease Acid reflux Constipation Gallstones Pancreatitis Stomach ulcers IBS Lactose

intolerance Polyps Ulcerative Colitis Liver Disease Jaundice Other (Please specify) _____

Review of Systems: If there are any symptoms, please check the box (es) that apply.

Ears, Nose, & Throat <input type="checkbox"/> Normal <input type="checkbox"/> hearing loss <input type="checkbox"/> trouble swallowing <input type="checkbox"/> ear infections <input type="checkbox"/> nose bleeds <input type="checkbox"/> sleep apnea <input type="checkbox"/> sinus infections <input type="checkbox"/> hoarseness <input type="checkbox"/> mouth sores <input type="checkbox"/> Other: _____	Endocrine <input type="checkbox"/> Normal <input type="checkbox"/> weakness/tired <input type="checkbox"/> hyperactive <input type="checkbox"/> hot sensitivity <input type="checkbox"/> cold sensitivity <input type="checkbox"/> poor growth <input type="checkbox"/> menstrual irregularity Age when periods started: ____ Cycles: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Other: _____	Cardiovascular <input type="checkbox"/> Normal <input type="checkbox"/> chest pain <input type="checkbox"/> palpitations <input type="checkbox"/> heart beats fast for no reason <input type="checkbox"/> fainting <input type="checkbox"/> heart murmur <input type="checkbox"/> congenital heart disease <input type="checkbox"/> Other: _____ Blood circulation <input type="checkbox"/> Normal <input type="checkbox"/> anemia <input type="checkbox"/> easy bruising <input type="checkbox"/> Other: _____
Urinary System <input type="checkbox"/> Normal <input type="checkbox"/> increased frequency or amount of urine <input type="checkbox"/> urinary tract infection <input type="checkbox"/> bedwetting <input type="checkbox"/> day time wetting <input type="checkbox"/> Other: _____	Gastrointestinal <input type="checkbox"/> Normal <input type="checkbox"/> trouble with bowel <input type="checkbox"/> gassiness <input type="checkbox"/> burping <input type="checkbox"/> diarrhea <input type="checkbox"/> Difficult swallowing <input type="checkbox"/> nausea/vomiting <input type="checkbox"/> excess weight gain <input type="checkbox"/> weight loss, how much ____ <input type="checkbox"/> poor appetite <input type="checkbox"/> excessive appetite <input type="checkbox"/> feeling full after a small meal <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Other: _____	Respiratory <input type="checkbox"/> Normal <input type="checkbox"/> wheezing <input type="checkbox"/> asthma <input type="checkbox"/> persistent coughing <input type="checkbox"/> shortness of breath with unusual exertion <input type="checkbox"/> pneumonia <input type="checkbox"/> shortness of breath for no reason <input type="checkbox"/> Other: _____
General <input type="checkbox"/> Normal <input type="checkbox"/> fever <input type="checkbox"/> excessive sweating <input type="checkbox"/> fatigue/tired <input type="checkbox"/> Other: _____	Psychology <input type="checkbox"/> Normal <input type="checkbox"/> feeling sad <input type="checkbox"/> feels upset easily <input type="checkbox"/> outburst of temper <input type="checkbox"/> feels hopeless <input type="checkbox"/> anxiety <input type="checkbox"/> behavior issues/problems <input type="checkbox"/> Ideas of hurting self and others <input type="checkbox"/> Other: _____	Eyes <input type="checkbox"/> Normal <input type="checkbox"/> glasses <input type="checkbox"/> contact lenses <input type="checkbox"/> itching of eyes <input type="checkbox"/> Other: _____
Musculoskeletal <input type="checkbox"/> Normal <input type="checkbox"/> bone problems <input type="checkbox"/> loose joints <input type="checkbox"/> scoliosis <input type="checkbox"/> joint problems <input type="checkbox"/> muscle pain <input type="checkbox"/> increased flexibility of joints <input type="checkbox"/> Other: _____	Neurology <input type="checkbox"/> Normal <input type="checkbox"/> seizures <input type="checkbox"/> developmental delay <input type="checkbox"/> headaches <input type="checkbox"/> dizziness <input type="checkbox"/> fainting <input type="checkbox"/> tremors <input type="checkbox"/> numbness <input type="checkbox"/> abnormal movements <input type="checkbox"/> decreased sensation <input type="checkbox"/> Other: _____	
Skin <input type="checkbox"/> Normal <input type="checkbox"/> eczema <input type="checkbox"/> dry skin <input type="checkbox"/> acne <input type="checkbox"/> diaper rash <input type="checkbox"/> bruising <input type="checkbox"/> itching <input type="checkbox"/> jaundice <input type="checkbox"/> Other: _____	Immunology <input type="checkbox"/> Normal <input type="checkbox"/> Allergies <input type="checkbox"/> Frequent infections <input type="checkbox"/> Unusual infections <input type="checkbox"/> swollen lymph node <input type="checkbox"/> Other: _____	

Social History:

Who all lives with the patient at home? (Please check all that apply)

- Both parents Mother Father Step-father Step-mother Foster parents Grandmother Grandfather Aunt(s) Uncle(s) Sibling(s) Significant other of parent Youth Home (If yes, how long? ____ what is the reason? _____)

Parental Status : Married Single Divorced Separated Unmarried Dual parenting

Patient's Sexual History: Not applicable Not currently sexually active Never sexually active Sexually active

If yes, does patient use protection? No Yes If active, how many partners? Single Multiple

Have you tried using alcohol? No Yes (If yes, please answer the following questions).

How much do you drink per week? 1-2 drinks 3-4 drinks 5+ drinks

Have you tried using tobacco? No Yes (If yes please, answer the following questions).

What type of tobacco? Cigarettes Cigars Chewing Snuff Hookah Juul E cigarettes

How often per week? 1-2 times 3-4 times 5+ times

If you smoke cigarettes, how many per day? 1-2 3-4 5-6 half a pack full pack

Have you tried using marijuana? No Yes (If yes please, answer the following questions).

How often per week? 1-2 times 3-4 times 5+ times

Does the patient have any pets? dog(s) cat(s) fish(es) other (please specify) _____

Does the patient attend school? No (Online Home School Other____) Yes (If yes, answer the following questions).

What school grade is the patient in? ____ What type of grades does the patient get? A's B's C's D's F's

Does the patient attend daycare? No Yes **What does the patient want to be when he/she grows up?** _____

What type(s) of sports does the patient participate in? _____

Please list the hobbies that the patient enjoys? _____

Diet History:

If your child is an infant/toddler, please answer the following questions:	If your child is older than a toddler, please answer the following questions:
Is your child currently being breastfed? <input type="checkbox"/> No <input type="checkbox"/> Yes If breastfed, how many feedings per day? ____ Is there supplementation with formula? <input type="checkbox"/> No <input type="checkbox"/> Yes If not breastfed, what type of formula? ____ How often? <input type="checkbox"/> 2 hr <input type="checkbox"/> 3 hrs <input type="checkbox"/> 4 hrs <input type="checkbox"/> 6 hrs How many ozs per feed? ____ Are you adding cereal to the formula? <input type="checkbox"/> No <input type="checkbox"/> Yes Other foods: _____ <input type="checkbox"/> Stage I baby food <input type="checkbox"/> Stage II baby food	How many servings of milk per day? ____ What type of milk? <input type="checkbox"/> 1% <input type="checkbox"/> 2% <input type="checkbox"/> Whole milk How many servings of vegetables per day? ____ How many servings of fruits per day? ____ How many cups of juice per day? ____ Does your child consume spicy foods? <input type="checkbox"/> No <input type="checkbox"/> Yes Does your child have diet restrictions? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please explain: _____

Development: Is your child's development: Normal Delayed (If yes, what is the determined developmental age? ____)

Please tell us anything else that you think may be important for us to know about your child.

Please let us know what your child would want to know from this visit

What are his/her concerns?

- Fear of clinic Fear of doctor Fear of needles Other: _____

What are your concerns? _____

Parent Name/Signature: _____ **Date:** _____