Progressive Child & Adolescent Gastroenterology
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Date: _____

Welcome to Pediatric Gastroenterology
New Patient Questionnaire for Constipation

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: _____
Previous treatments tried: _____ **Duration of Use:** _____
How often does patient pass stool? ☐ Daily ☐Every other day ☐2-3 times per week ☐Once per week ☐Once per 2 weeks ☐Other:_____
Is there blood in the stool? ☐ No ☐ Yes If yes, are there surface streaks? ☐ No ☐ Yes Is there mixed stools? ☐ No ☐ Yes
Is there blood on wipe? ☐ No ☐ Yes
Is there painful defecation? ☐ No ☐ Yes **Does the patient strain to pass stool?** ☐ No ☐ Yes
Is there soiling of the underwear?☐ No ☐ Yes **Does the patient have diarrhea?** ☐ No ☐ Yes
Are there skid marks? ☐ No ☐ Yes Is there a small amount? ☐ No ☐ Yes
Is there a moderate amount? ☐ No ☐ Yes Is there a large amount? ☐ No ☐ Yes
Are there large bulky stools? ☐ No ☐ Yes
Other associated symptoms: ☐ Rectal prolapse ☐ Chronic cough ☐ Hemorrhoids☐ Bedwetting ☐Frequent urination ☐History of urinary tract infection
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 ☐ No ☐Yes		
Foods ☐No ☐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

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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 ☐Normal ☐hearing loss ☐trouble swallowing ☐ear infections ☐nose bleeds ☐sleep apnea ☐sinus Infections ☐hoarseness ☐mouth sores ☐Other: _____	**Endocrine** ☐Normal ☐weakness/tired ☐hyperactive ☐hot sensitivity ☐cold sensitivity ☐poor growth ☐menstrual irregularity **Age when periods started:** __ **Cycles:** ☐Regular ☐Irregular ☐Other:_____	**Cardiovascular** ☐Normal ☐chest pain ☐palpitations ☐heart beats fast for no reason ☐fainting ☐heart murmur ☐congenital heart disease ☐Other:_____ **Blood circulation** ☐ Normal ☐anemia ☐easy bruising ☐Other: _____
Urinary System ☐ Normal ☐increased frequency or amount of urine ☐urinary tract infection ☐bedwetting ☐day time wetting ☐Other: _____	**Gastrointestinal** ☐Normal ☐trouble with bowel ☐gassiness ☐burping ☐diarrhea ☐Difficult swallowing ☐nausea/vomiting ☐excess weight gain ☐weight loss, how much ____ ☐poor appetite ☐excessive appetite ☐feeling full after a small meal ☐rectal bleeding ☐Other: _____	**Respiratory** ☐ Normal ☐wheezing ☐asthma ☐persistent coughing ☐shortness of breath with unusual exertion ☐pneumonia ☐shortness of breath for no reason ☐Other: _____
General ☐Normal ☐fever ☐excessive sweating ☐fatigue/tired ☐Other:_____		**Eyes** ☐Normal ☐glasses ☐contact lenses ☐itching of eyes ☐Other: _____
Musculoskeletal ☐Normal ☐bone problems ☐loose joints ☐scoliosis ☐joint problems ☐muscle pain ☐increased flexibility of joints ☐Other: _____	**Psychology** ☐ Normal ☐feeling sad ☐feels upset easily ☐outburst of temper ☐feels hopeless ☐anxiety ☐behavior issues/problems ☐ideas of hurting self and others ☐Other:_____	**Neurology** ☐Normal ☐seizures ☐developmental delay ☐headaches ☐dizziness ☐fainting ☐tremors ☐numbness ☐abnormal movements ☐decreased sensation ☐Other:_____
Skin ☐Normal ☐eczema ☐dry skin ☐acne ☐diaper rash ☐bruising ☐itching ☐jaundice ☐Other: _____		**Immunology** ☐Normal ☐Allergies ☐Frequent infections ☐Unusual infections ☐swollen lymph node ☐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?☐ No ☐Yes If breastfed, how many feedings per day? _____ Is there supplementation with formula? ☐No ☐Yes If not breastfed, what type of formula? _____ How often?☐2 hr ☐3 hrs ☐4 hrs ☐6 hrs How many ozs per feed?___ Are you adding cereal to the formula? ☐No ☐Yes Other foods: _____ ☐ Stage I baby food ☐ Stage II baby food	How many servings of milk per day? _____ What type of milk? ☐1% ☐2% ☐ 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? ☐No ☐Yes Does your child have diet restrictions? ☐No ☐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:** _____