PHOENIX CHILDREN'S Medical Group®

PEDIATRIC GASTROENTEROLOGY PARENT QUESTIONNAIRE

Please answer as many of the following questions as you can while waiting for the doctor. Use back of page if needed.

Your child's main doctor: _____

Other Doctors: _____

_____

List of medications: (Include doses of vitamins, Tylenol, breathing treatments, oxygen and lotions)

_____

_____

_____

Are your child's immunizations current?_____

The main reason for bringing your child in today:_____

_____

_____

What your child eats and drinks in a typical day including the amount: _____

_____

_____

_____

List all hospitalizations: (date and reason): _____

_____

_____

Surgeries:_____

_____

List all past illnesses:_____

_____

Accidents/Fractures:_____

_____

What is your child's birth weight: _____ Allergies to medicine: _____

List all people living in the home by relation to your child (mother, sister, etc.) including age of children:

_____

_____

_____

List any illnesses in relatives or family members:_____

_____

_____

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GI/Liver

Has your child ever had any of the following?

- ☐ Unexplained Weight Loss
- ☐ Excessive Weight Gain
- ☐ Difficulty Gaining Weight
- ☐ Diarrhea
- ☐ Constipation
- ☐ Rectal Pain
- ☐ Nausea / Vomiting
- ☐ Jaundice (yellowing of eyes / skin)
- ☐ Gallstones
- ☐ Soiling Pants (after 5 years old)
- ☐ Food Allergies with GI symptoms
- ☐ Abdominal Pain, describe location:
  - ☐ Above Belly Button:
    - _____ Right side
    - _____ Center
    - _____ Left side
  - ☐ Below Belly Button:
    - _____ Right side
    - _____ Center
    - _____ Left side
- ☐ Blood in the Stool
- ☐ Black / Tarry Stools
- ☐ Change in Appetite
- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ Choking with Feeds
- ☐ Colic
- ☐ Oily or Greasy Stools
- ☐ Pancreatitis
- ☐ Liver Disease
- ☐ Ulcers

OTHER Please describe: _____

In addition, has your child ever had any of the following?

- ☐ Recurrent Fever
- ☐ Vision Changes
- ☐ Wheezing−Asthma
- ☐ Chronic Cough
- ☐ Abnormal Blood Pressure
- ☐ Abnormal Heart Rhythm
- ☐ Seizures
- ☐ Recurrent Urinary Tract Infections
- ☐ Skin Rash / Birth Mark
- ☐ Easy Bruising / Bleeding Tendencies
- ☐ Thyroid Problems
- ☐ Depression
- ☐ Joint Pains or Swelling
- ☐ Recurrent Ear Infections
- ☐ Pneumonia
- ☐ Dizziness / Fainting
- ☐ Heart Murmur
- ☐ Headache
- ☐ Numbness
- ☐ Urinary Incontinence
- ☐ Tremors
- ☐ Anemia
- ☐ Seasonal Allergies
- ☐ Anxiety
- ☐ OTHER: Please describe: _____

Family History: Is there a family member with any of the following?

- ☐ Allergies
- ☐ Asthma
- ☐ Recurrent Miscarriages / Fetal Deaths
- ☐ Cirrhosis
- ☐ Crohn's Disease
- ☐ Diabetes
- ☐ Food Allergy / Celiac Disease
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Migraine Headaches
- ☐ Depression or Anxiety Disorders
- ☐ Ulcerative Colitis
- ☐ Arthritis
- ☐ Birth Defects
- ☐ Cancer
- ☐ Colitis
- ☐ Cystic Fibrosis
- ☐ Feeding problems
- ☐ Gall Bladder Disease
- ☐ High Blood Pressure
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Liver Disease
- ☐ Pancreatitis
- ☐ Thyroid Disease
- ☐ Ulcers (peptic or stomach)
- ☐ OTHER: Please describe: _____

Signature of Patient/Legally Authorized Representative: _____ Relationship to Patient: _____

Printed Name of Patient/Legally Authorized Representative: _____ Date &Time: _____

Practitioner Signature: _____ Date & Time: _____

Printed Name: _____