ANNAPOLIS PEDIATRIC GASTROENTEROLOGY & NUTRITION
INTAKE FORM

Date: ______________

Patient's Name: ________________________
Date of Birth: __________________________

Reason for visit: ____

Birth History:

Birth weight: _____ lbs _____ oz   Full-term? ☐ Yes ☐ no
(If "no" how early?) ______weeks

Were there any problems:	**Yes**	**No**
With pregnancy?	☐	☐
With labor?	☐	☐
With delivery?	☐	☐
In the nursery?	☐	☐
With jaundice?	☐	☐
With constipation?	☐	☐

Early GI History:

In the first 2 years of life, did your child have problems with?

Bloody stools	☐	☐
Diarrhea / loose stools	☐	☐
Milk allergy	☐	☐

Did he/she receive multiple courses of antibiotics within first three years of life? Yes☐ No☐

Feeding History:	**Yes**	**No**	
Was your child breastfed as a newborn?	☐	☐	How long? __________
Was your child formula-fed as a newborn?	☐	☐	

If formula, which one and how long? ____
At what age was cow's milk introduced? ______________________________________
How would you describe his/her current diet?
Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____
____
Does he/she like milk, cheese and ice cream? __________________________________
Are any foods currently restricted from the diet? ______________________________

Development:

Has your child's growth and development been normal? Yes☐ No☐
If "no" explain ____
____

For school age children:

What grade is your child in? ____
Number of school days missed because of present problem: ___________________
How is his/her school performance? _____________________________________

Medical History:

Has your child ever?	**Yes**	**No**
Been hospitalized overnight	☐	☐
Had any surgery	☐	☐

If YES, please explain____

____

If your child had any surgery, is there any problem with sedation or anesthesia? __________

____

Has your child had any serious problems?

	Yes	**No**
His/her eyes, ears, nose or throat	☐	☐
Eczema	☐	☐
Rash	☐	☐
Chronic fever	☐	☐
Night sweats	☐	☐
Weight loss	☐	☐
Breathing (pneumonia, asthma, etc.)	☐	☐
His/her heart or blood pressure	☐	☐
Rapid heart rate	☐	☐
Heart murmur	☐	☐
A kidney or bladder infection	☐	☐
Joint, bones or muscles	☐	☐
Seizures	☐	☐
Headaches	☐	☐
Fainting, dizziness when getting up	☐	☐
Trouble with hot or cold temperature	☐	☐
Flushing, or abnormal sweating	☐	☐
Seasonal Allergies	☐	☐
Anemia	☐	☐
Snoring/Sleep Apnea	☐	☐
Are your child's immunizations up to date?	☐	☐

Allergies: ______________________ Does your child have LATEX allergy? __________

Current medications: ____

____

The last time your child-received antibiotics: ____

Family History:	**Yes**	**No**
Who lives at home with the patient? ____		
Are natural parents separated?	☐	☐
Names and ages of brothers and sister: ____		
Do you have pets?	☐	☐ What kind? ___________
Are there smokers in the household?	☐	☐
Does the patient smoke?	☐	☐
What type of water do you have?	City _____	Well _____
Has your family traveled outside of Maryland in the past year?	☐	☐

If "yes", where: ____

Has anyone in the family suffered from:	**Yes**	**No**
Cystic fibrosis	☐	☐
Celiac sprue disease	☐	☐
Chronic diarrhea	☐	☐
Crohn's disease	☐	☐
Ulcerative colitis	☐	☐
Stomach ulcers	☐	☐
Jaundice	☐	☐
Hepatitis	☐	☐
Liver disease	☐	☐
Cirrhosis of the liver	☐	☐
Pancreatitis	☐	☐
Gallstones	☐	☐
Chronic abdominal pain	☐	☐
Spastic colon	☐	☐
Irritable bowel	☐	☐
Colon or rectal polyps	☐	☐
Constipation	☐	☐
Food allergies	☐	☐
Migraines	☐	☐

Are the any other medical problems that run in the family? ________________________________
____
____

Is there any family member with history of difficulty with sedation or anesthesia? If YES, please explain the problem.____
____

Please list physician(s) who you want to receive reports of your child's evaluation:

Name: ____________________________
Address: __________________________
____
Phone: ( ) _________________________
Fax: ( ) __________________________

Name: __________________________
Address: ________________________
____
Phone: ( ) _____________________
Fax: ( ) ________________________