

# New Patient Visit

Place Sticker Here

Outpatient GI Attending: \_\_\_\_\_

Pediatrician: \_\_\_\_\_

## Physical Examination

Pulse bpm	BP:	T:	RR:	Wt:	Ht:
				Wt %:	Ht %:

Please help us to care for you and your family by filling out the "Patient" side of this form.

### Patient

Why are you here to see us today?

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Please complete the following section by answering **yes** or **no** to the questions:

Does your child complain of:

- Abdominal pain? Y N
  - Does it interrupt play? Y N
  - Wake from sleep? Y N
- Does your child have vomiting? Y N
  - Does it dribble out? Y N
  - Does it shoot out? Y N
  - Is there blood? Y N
  - What color is it? \_\_\_\_\_
- How many bowel movements does your child have each day? \_\_\_\_\_
  - Are they liquid? Y N
  - Are they in pieces? Y N
  - Are they formed or hard? Y N
- Is there blood with bowel movements?
  - Is it mixed in the stool? Y N
  - Is it in the toilet water? Y N
  - Is it on the toilet paper? Y N
- Does your child have fevers? Y N
- Does your child have sores in their mouth? Y N
- Does your child have a rash? Y N
- Does your child complain of joint pain or swelling? Y N

### Clinician

Chief Complaint:

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### History of Present Illness:



**Patient**

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**Growth and Development:**

- Has your child's growth and development been normal? Y N
  - How does he/she compare to your other children?
- 
- 

At what age did he/she?

- Roll over?
- Sit up?
- Pull to stand?
- Walk?
- Say first words?
- Put words together?

**Growth Data:**

- Please check your records and provide as many heights and weights as possible.

Date	Weight	Height
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Immunization Status:**

- DPT       OPV
- M/MR     HIB
- Hep B     Varicella (chicken pox)

- Who lives at home with the patient?

- Names and ages of brothers and sisters?

- Do you have any pets? Y N
- Do you have city or well water? \_\_\_\_\_
- Treated with fluoride? Y N
- Travel outside the region lately? Y N
- What grade is your child in? \_\_\_\_\_
- How is their attendance record and performance? \_\_\_\_\_
- How many close friends do they have? \_\_\_\_\_

**Clinician**

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**Immunizations:**

**Social History:**

**Patient**

- Are there medical problems that run in the family?  
(parents, siblings, grandparents)
  - cystic fibrosis
  - celiac sprue
  - chronic diarrhea
  - Crohn's disease
  - ulcerative colitis
  - ulcers
  - jaundice
  - hepatitis
  - liver disease/cirrhosis
  - pancreatitis
  - chronic abdominal pain
  - spastic colon/irritable bowel
  - polyps
  - colon cancer

- Has your child had problems with:
  - their eyes, ears, nose or throat
  - breathing (asthma, pneumonia, etc.)
  - their heart or blood pressure
  - kidney or bladder infection
  - joints, bones or muscles
  - recurrent skin rashes

What is your family's ancestry/ethnicity?  
\_\_\_\_\_

What is mom's height?  
\_\_\_\_\_

What is dad's height?  
\_\_\_\_\_

Doctors involved in your child's health care:  
**Circle those whom you want reports sent to.**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**Clinician**

**Family History:**

**Review of Systems:**

	N/A	Comments & Description
Constitutional		
HEENT		
Cardiovascular		
Respiratory		
Genitourinary		
Neuro/Devel		
Musculoskeletal		
Skin		
Other		