Patient Name & Date of Birth ________________________________

G.I. PATIENT HISTORY FORM

Referring Physician ____

Primary Care Physician ____

Have you been seen by another GI specialist? ◻ yes ◻ no

If yes, where, what provider and when? _________________________

Pharmacy name/location____

Why have you scheduled this appointment?_________________________

Any recent labs/x-rays ◻ yes ◻ no

If so, when/where were they done? ____________________________

Has patient ever had a colonoscopy or endoscopy? ◻ yes ◻ no

If so, when/where? ____

Gastrointestinal Symptoms:

	No	Yes	explain
Nausea or vomiting	_____	_____	______________________________
Vomiting blood or bile	_____	_____	______________________________
Food refusal	_____	_____	______________________________
Appetite change	_____	_____	______________________________
Gagging/ coughing/Choking with food	_____	_____	______________________________
Trouble swallowing	_____	_____	______________________________
Heartburn	_____	_____	______________________________

Abdominal pain:

How long have you had pain? ____

How often does it happen/what time of day? ________________________________

What does the pain feel like?____

How long does the pain last? ____

Any pain at night when sleeping? ◻ yes ◻ no

If yes, does the pain wake you up? ◻ yes ◻ no

Is the pain better or worse with food? ________________________________

What type of food affects the pain? __________________________________

Does the pain improve with a bowel movement?___________________________

What have you tried to help with the pain?_____________________________

How much school is missed because of pain? ____________________________

Bowel History:

Toilet trained □ yes □ no

Any bed wetting? □ yes □ no

How often does patient have stools? ____

Are stools □ "hard formed"

□ "soft formed"

□ "pudding consistency"

□ "watery"

Do stools vary in consistency? ____

Does patient take laxatives to produce stools? □ yes □ no

Does patient have accidents with stool in underwear? □ yes □ no

Does patient exhibit any stool withholding behavior? □ yes □ no

Any blood in stools? □ yes □ no

Any mucous in stools? □ yes □ no

Any black/tarry stools? □ yes □ no

Other/GI:

Liver disease □ yes □ no

Jaundice □ yes □ no

Gallbladder disease □ yes □ no

Irritable Bowel disease □ yes □ no

Inflammatory Bowel disease □ yes □ no

Patient Medical History:

Allergies: Medications/Foods/Environmental/Seasonal___________________________________

Medications/dosage: ____

Previous illnesses: ____

Past surgeries/hospitalizations: ____

Are immunizations up-to-date: □ yes □ no

If not up-to-date, what is delinquent?____

Any developmental concerns?____

Personal/Social History:

Patient lives with: □ mom □ dad □ both parents □ Other

Siblings/ages ____

Grades in school/performance ____

# of days missed ____

Anyone smoke at home?____

Pets at home?____

Activities/interests ____

Recent stress or change? ____

Diet:

Diet (type of formula/foods) ____

History of formula(s) previously tried, type, when & how long______________________________

Any intolerance to milk □ yes □ no

Intake of milk _____________oz

Intake of juice/Gatorade/pop: _______________oz/per day

Birth History:

What was the gestational age of the patient at birth?_________________________

Was patient born by vaginal delivery or C-section?_______________________________________

Problems during pregnancy? ____

Problems at birth? ____

What was the patient's birth weight/length?____

Was the patient's first stool passage within the first 24 hours? □ yes □ no

Family History: (Mom, Dad, Sibling, Maternal Grandparent, Paternal Grandparent)

Colitis □ yes □ no
If yes, who? ________________________________

Inflammatory Bowel Disease □ yes □ no
If yes, who? ________________________________

Ulcerative Colitis □ yes □ no
If yes, who? ________________________________

Crohn's □ yes □ no
If yes, who? ________________________________

Colon Polyps □ yes □ no
If yes, who? ________________________________

Colon Cancer □ yes □ no
If yes, who? ________________________________

Celiac Disease □ yes □ no
If yes, who? ________________________________

Irritable Bowel Syndrome □ yes □ no
If yes, who? ________________________________

Allergies □ yes □ no
If yes, who? ________________________________

Asthma □ yes □ no
If yes, who? ________________________________

Thyroid (hypo or hyper) □ yes □ no
If yes, who? ________________________________

Liver Disease □ yes □ no
If yes, who? ________________________________

Diabetes □ yes □ no
If yes, who? ________________________________

Mental Health Issues □ yes □ no
If yes, who? ________________________________

Other Family History
What Disease & Who?

REVIEW OF SYSTEMS:

General:

Weight loss □ yes □ no

If yes, how much?________________________

Weight gain □ yes □ no

If yes, how much?_______________________

Unexplained fevers □ yes □ no

Unusual fatigue □ yes □ no

Poor appetite □ yes □ no

Poor sleeping □ yes □ no

Skin:

Eczema □ yes □ no

Rashes □ yes □ no

ENT:

Frequent ear infections □ yes □ no

Sores in mouth □ yes □ no

Sinus problems □ yes □ no

Respiratory:

Pneumonia □ yes □ no

Asthma/wheezing □ yes □ no

Chronic cough □ yes □ no

Cardiovascular:

Heart murmur □ yes □ no

Heart disease □ yes □ no

GU:

Blood in urine □ yes □ no

Pain with urination □ yes □ no

Frequent urination □ yes □ no

Kidney disease or stones □ yes □ no

Frequent urinary infections □ yes □ no

History of sexually transmitted diseases _______________________________________

Gynecological (females only):

When was 1st period?________________

Regular periods □ yes □ no

Ovarian cysts ☐ yes ☐ no

Endometriosis ☐ yes ☐ no

Sexually active ☐ yes ☐ no

Type of birth control______________________

Had a gynecology exam ☐ yes ☐ no

If so, when?____________________________

Muscle/Skeletal:

Joint pain/stiffness ☐ yes ☐ no

Back pain ☐ yes ☐ no

Hematology/Lymphatic:

Enlarged lymph nodes ☐ yes ☐ no

Excessive bruising ☐ yes ☐ no

Bleeding of gums ☐ yes ☐ no

Nose bleeds ☐ yes ☐ no

History of anemia ☐ yes ☐ no

Neurologic:

Seizures ☐ yes ☐ no

Frequent headaches ☐ yes ☐ no

Migraine headaches ☐ yes ☐ no

Unusual/excessive fussiness/irritability

☐ yes ☐ no

Endocrine:

Diabetes ☐ yes ☐ no

Thyroid ☐ yes ☐ no

Growth problems ☐ yes ☐ no

Psychosocial:

Anxiety ☐ yes ☐ no

Depression ☐ yes ☐ no

School avoidance ☐ yes ☐ no

Recent stresses ☐ yes ☐ no

Abuse (physical, emotional, sexual)

□ yes □ no

Insomnia/ trouble sleeping □ yes □ no

Drug/alcohol use □ yes □ no

Special Services:

Speech therapy □ yes □ no

Occupational therapy □ yes □ no

Physical therapy □ yes □ no

Special education □ yes □ no