

**The Children's Hospital of Philadelphia
The Division of Gastroenterology, Hepatology, & Nutrition**

34th Street and Civic Center Boulevard, Philadelphia, PA 19104-4399 Tel: 215-590-1000; Fax: 215-590-3606.

New Patient Form: Please complete by checking the boxes / writing clearly in the space provided.

Patients name:	Date this form is completed:
Date of birth: MR No:	Name of person completing the form:
Patient referred by:	Relationship to patient:
Patient accompanied by:	

Please list the doctors involved in the care of the patient:

PMD Practice:	Specialty:
Name:	Name:
Address:	Address:
Tel:	Tel:
Specialty:	Specialty:
Name:	Name:
Address:	Address:
Tel:	Tel:

Pharmacy Information:

Name:	State & Zip :
Street address:	Phone No.:
Town :	Fax No.:

What are the problems that bring your child to the GI doctor?

<input type="checkbox"/> abdominal pain	<input type="checkbox"/> constipation	Other <input type="checkbox"/>
<input type="checkbox"/> vomiting	<input type="checkbox"/> blood in stool	<input type="checkbox"/>
<input type="checkbox"/> reflux	<input type="checkbox"/> loose stool / diarrhea	<input type="checkbox"/>
<input type="checkbox"/> choking	<input type="checkbox"/> accidents with stool	<input type="checkbox"/>
<input type="checkbox"/> feeding difficulty	<input type="checkbox"/> liver disease	<input type="checkbox"/>
<input type="checkbox"/> poor growth	<input type="checkbox"/> jaundice	
<input type="checkbox"/> weight loss	<input type="checkbox"/> abnormal lab results	

Does your child have any known allergies?

Allergies	Allergen(s)	Explain what the reaction(s) were:
Drugs <input type="checkbox"/> No <input type="checkbox"/> Yes		
Latex <input type="checkbox"/> No <input type="checkbox"/> Yes		
X-ray dyes <input type="checkbox"/> No <input type="checkbox"/> Yes		
Blood products <input type="checkbox"/> No <input type="checkbox"/> Yes		
Contact <input type="checkbox"/> No <input type="checkbox"/> Yes		
Foods <input type="checkbox"/> No <input type="checkbox"/> Yes		

Check if any of the following medical conditions is relevant to your child:

G6PD deficiency <input type="checkbox"/> No <input type="checkbox"/> Yes	Ketogenic diet <input type="checkbox"/> No <input type="checkbox"/> Yes
Malignant Hyperthermia <input type="checkbox"/> No <input type="checkbox"/> Yes	Prolonged QT <input type="checkbox"/> No <input type="checkbox"/> Yes

Does your child need pre-medication(s) or antibiotic(s) prior to dental procedures/surgery:

<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, explain:

List your child's current medications (including over-the-counter and supplements):

Medication	Dose / strength	How often?	Directions for use
			<input type="checkbox"/> Oral <input type="checkbox"/> Other
			<input type="checkbox"/> Oral <input type="checkbox"/> Other
			<input type="checkbox"/> Oral <input type="checkbox"/> Other
			<input type="checkbox"/> Oral <input type="checkbox"/> Other
			<input type="checkbox"/> Oral <input type="checkbox"/> Other
			<input type="checkbox"/> Oral <input type="checkbox"/> Other
			<input type="checkbox"/> Oral <input type="checkbox"/> Other
			<input type="checkbox"/> Oral <input type="checkbox"/> Other
			<input type="checkbox"/> Oral <input type="checkbox"/> Other
			<input type="checkbox"/> Oral <input type="checkbox"/> Other

If you were interviewed by a nurse from our office and have already given the information below over the phone, you do not need to complete the rest of pg 2 & pg 3.

Pregnancy and Birth History (Answer only if your child is <8 years)

Were there any complications during pregnancy? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, check the relevant ones or explain: <input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> Elevated BP <input type="checkbox"/> Pre-eclampsia <input type="checkbox"/> Pre-term contractions <input type="checkbox"/> Meconium aspiration <input type="checkbox"/> Poly-hydramnios <input type="checkbox"/> other-
How many weeks into pregnancy (Gestational age) was the baby delivered? : _____ weeks How was the baby delivered? <input type="checkbox"/> vaginal <input type="checkbox"/> vacuum <input type="checkbox"/> forceps <input type="checkbox"/> cesarean If cesarean, indication?
Baby's Birth weight: _____ lbs _____ oz Birth length: _____ inches Any complications with baby at birth? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, check the relevant ones or explain: <input type="checkbox"/> jaundice requiring phototherapy <input type="checkbox"/> Neonatal ICU for
When did the baby have the first bowel movement (meconium)? <input type="checkbox"/> <48 -72hours <input type="checkbox"/> >72 hours <input type="checkbox"/> not sure Was your baby breast fed? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, for how long? What were the formulas used?

Immunization History of your child

Are the immunizations up to date?	DTP <input type="checkbox"/> yes <input type="checkbox"/> no	Varicella <input type="checkbox"/> yes <input type="checkbox"/> no	MD/CRNP notes
<input type="checkbox"/> yes <input type="checkbox"/> no	Polio <input type="checkbox"/> yes <input type="checkbox"/> no	Hepatitis A <input type="checkbox"/> yes <input type="checkbox"/> no	
If not, why?	HIB <input type="checkbox"/> yes <input type="checkbox"/> no	Influenza <input type="checkbox"/> yes <input type="checkbox"/> no	
	Hepatitis B <input type="checkbox"/> yes <input type="checkbox"/> no	Other:	
	MMR <input type="checkbox"/> yes <input type="checkbox"/> no		

Has your child ever been admitted to a Hospital (excluding ER visit)? No Yes. If yes, please explain

When?	Which hospital?	Reason for admission?	MD/CRNP notes

Please enter your child's Past Medical and Past Surgical History

Systems	Past Medical History	Surgical History <input type="checkbox"/> none	MD/CRNP notes
GI			
ENT			
Lungs			
Heart			
Nervous system			
Endocrine			
Urology			
Psych			

Family/Social History

Who lives at home with the patient?	Is your child in daycare? <input type="checkbox"/> No <input type="checkbox"/> Yes	Family ancestry/ethnic background:
	What Grade is child in?	
	How is the attendance at school?	
Name and ages of brothers and sisters:		Bio. Mom's height: ft in
	How is the school performance?	Bio. Dad's height : ft in
		MD/CRNP notes
	Do you have any safety concerns?	
Do you have any pets? <input type="checkbox"/> No <input type="checkbox"/> Yes		
If yes, mention	Any recent travel outside region?	
Home water supply: <input type="checkbox"/> well <input type="checkbox"/> city		

Family Medical History: Please check the relevant boxes

Medical Problem	Abdominal pain	Allergy	Asthma	Celiac disease	Chronic diarrhea	Colon cancer	Constipation	Crohn disease	Cystic Fibrosis	GERD	Hirschsprung's	Irritable Bowel	Migraine	Pancreatitis	Polyyps	Thyroid disease	Ulcers	Ulcerative colitis	Liver disease	Gallstones	Jaundice	Hepatitis	Cirrhosis	MD/CRNP notes	
Sister																									
Brother																									
Biological Mom																									
Biological Dad																									
Maternal GM																									
Maternal GF																									
Paternal GM																									
Paternal GF																									
Other																									

