PEDIATRIC GASTROENTEROLOGY ASSOCIATES
CARING FOR KIDS AND ADOLESCENTS
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PEDIATRIC PATIENT HISTORY SHEET

Patient Name _____DOB _____

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1) Please describe the nature of your child's problem or symptoms:

_____

_____

_____

2) How long has your child had this problem? _____

3) Has your child seen another doctor for this problem? _____If yes:

A) What was your child diagnosed with? _____

B) What treatment did your child receive? (Med's) _____

C) Did your child receive any x-rays, lab test or have any procedures done for this problem? _____If yes, list what and where it was done:

_____

_____

_____

4) List any medications/formula your child is currently taken:

_____

_____

_____

5) Please place an (X) to any of the following problems that your child has now:

_____ Vomiting (approx. _____ times a day)

_____ Trouble with bowels

_____ Nausea

_____ Trouble with stomach or digestive system

_____ Constipation

_____ Diarrhea (approx. _____ stools a day)

_____ Heartburn

_____ Weight changes (gained _____lbs/loss_____ lbs)