Weill Cornell Medicine
Pediatric
Gastroenterology

NewYork-Presbyterian
Phyllis and David Komansky
Center for Children's Health
Weill Cornell Medical Center

Pediatric Gastroenterology & Nutrition

Weill Cornell Medical Center
New York Presbyterian Hospital
505 E 70th Street 3rd Floor
New York, NY 10021

Phone: 646-962-3869
Fax: 646-962-0246

Robbyn Sockolow, MD
Director, Pediatric GI

Elaine Barfield, MD

Kimberley Chien, MD
Thomas Ciecierega, MD
Neera Gupta, MD
Aliza Solomon, DO

NEW PATIENT QUESTIONNAIRE

Please complete this questionnaire. It will be an important part of your child's medical record.

Complete Your Child's Name: _____

Child's DOB: Child's Age:

Pediatrician's Name:

Pediatrician's Address: Telephone:

☐ **Self Referral** ☐ **Consultation/Referred by Dr.** _____

What is the reason for your child's visit today? _____

_____

_____

A. Past Medical History

1. Birth History: Birth Weight: Length: Place of birth: ☐ Full Term ☐ Premature

Labor/Delivery: ☐ Vaginal ☐ C-section Describe any problems:

Pregnancy problems:

Problems in the Nursery/1st month of life:

2. List all **CURRENT** medications **(include over the counter and herbal therapies and vitamins).**

Current Medications	**Dose**	**How often**

List any known medical problems that your child has (ie, asthma, reflux, Crohn's, diabetes, thyroid disease, etc)

1.
2.
3.

3. List any hospitalizations that your child has had. Include his/her age, where hospitalized, and the reason for the hospitalization.

4. Drug/Medication Allergies: _____

5. Food Allergies: _____

6. Are your child's immunizations up to date? ☐ Yes ☐ No

5. List any surgeries/procedures with the dates performed that your child has had. Include those done as an outpatient.

B. Family History

1. Has anyone in the patient's family (or relative) had any of the following? If yes, check the box and list the person's relationship to the patient next to the problem.

☐ Migraine headaches	☐ High blood pressure	☐ Gallstones/ gall bladder problem
☐ Seizures	☐ Heart disease or stroke	☐ Gastritis/ulcer
☐ Mental retardation/developmental delay	☐ Diabetes	☐ Colitis, Crohns disease
☐ Asthma, Emphysema	☐ Anemia	☐ Celiac disease
☐ Cystic Fibrosis	☐ High cholesterol	☐ Liver problems
☐ Sickle cell disease or trait	☐ Constipation	☐ Blood in stool
☐ Cancer (list type)	☐ Polyps	☐ Irritable bowel syndrome

2. Is there any other disease/illness that runs in the family?

_____

C. Social History:

1. Who lives in the same household as the patient?

Name	Age	Relationship to patient	Any health problems

2. Are the parent(s): ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Remarried

3. School History:

A) Grade in school:

B) Performance/Grades

C) Recent change in behavior/performance?

4. Any unusual stresses at home or school? ☐ Yes ☐ No

If yes, please explain: _____

D. Child's Review of Systems: Please check any of the following that are problems *for your child*:

***(IF* NOTHING IS CHECKED IT IS ASSUMED TO BE NEGATIVE)**

General
- ☐ Weight change
- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Poor appetite
- ☐ Fatigue

Eyes
- ☐ Vision change
- ☐ Eye pain

Ear, Nose, Throat
- ☐ Ear pain

Heart/ Blood vessels
- ☐ Chest pain
- ☐ Palpitations (fast heart beat)
- ☐ Extremity swelling
- ☐ Fainting
- ☐ Irregular heart beat
- ☐ Blood pressure problems

Breathing/Lungs/Chest
- ☐ Shortness of breath
- ☐ Cough
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Snoring

Gastrointestinal (Stomach / Intestines)
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting or spitting up
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation (hard OR infrequent stool)
- ☐ Reflux
- ☐ Blood in vomit
- ☐ Blood in stool
- ☐ Liver problems or hepatitis
- ☐ Jaundice (yellowing of skin)

- ☐ Ear infections
- ☐ Nasal congestion
- ☐ Bloody nose
- ☐ Mouth sores/ulcers
- ☐ Trouble swallowing
- ☐ Dental problems
- ☐ Sour taste in mouth
- ☐ Hoarseness
- ☐ Apnea (stops breathing)
- ☐ Asthma
- ☐ Pneumonia

Skin

- ☐ Rash
- ☐ Hair loss
- ☐ Eczema

Musculoskeletal (Bones/muscles)

- ☐ Joint pain (knees, wrist, fingers, hips, etc)
- ☐ Muscle pain
- ☐ Fractures (broken bones)
- ☐ Bone pain

Breasts

- ☐ Nipple discharge
- ☐ Breast lumps/masses

Genital/Urinary System

- ☐ Increased urine frequency
- ☐ Urgency
- ☐ Urinating at night
- ☐ Blood in urine
- ☐ Pain with urination
- ☐ Genital lesions
- ☐ Absent periods
- ☐ Menstrual problems
- ☐ Age at first menstrual period _____
- ☐ Date of last menstrual period _____

Neurological

- ☐ Weakness
- ☐ Headache
- ☐ Memory loss
- ☐ Seizures
- ☐ Vertigo or dizziness
- ☐ Tremor
- ☐ Tingling
- ☐ Developmental delay
- ☐ ADHD (hyperactivity)
- ☐ Decreased sensation
- ☐ Decreased muscle strength
- ☐ Curved spine

Hematology/Blood

- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Anemia
- ☐ Thalassemia
- ☐ Received blood transfusions
- ☐ Swollen lymph nodes
- ☐ Bleeding problem/disorder

Allergy/Immune systen

- ☐ Hives
- ☐ Anaphylaxis
- ☐ Lip swelling
- ☐ Skin feels tight
- ☐ Morning stiffness
- ☐ Raynaud's syndrome
- ☐ Frequent infections
- ☐ Unusual infections

Psychiatric

- ☐ Depressed mood
- ☐ No longer do activities you enjoy
- ☐ Anxiety
- ☐ Thoughts of suicide (hurting yourself)
- ☐ Hallucination

Endocrine

- ☐ Always feel hot
- ☐ Always feel cold
- ☐ Increased urination
- ☐ Increased thirst
- ☐ Poor growth
- ☐ Diabetes
- ☐ Thyroid problems

E. Feeding History:

1. How was your child fed as an infant? ☐ Breast-fed ☐ Bottle-fed
   a) If breast-fed, for how long? If formula-fed, what formula did (does) your child receive?
2. Is your child on a special or restricted diet now? ☐ Yes ☐ No
3. Is your child's appetite normal, increased or decreased?

F. Stooling history:

Did your child pass meconium (black sticky stool) in the first 24-48 hours of life? ☐ Yes ☐ No

Did your child have normal stooling as a baby? ☐ Yes ☐ No

How often does your child have a bowel movement now?

When was your child's last bowel movement?

Does your child have accidents (soils underpants)? ☐ Yes ☐ No

Is your child's stool malodorous (smell worse than normal)? ☐ Yes ☐ No

What is the consistency of your child's stool? ☐ Loose ☐ Watery ☐ Soft/mushy ☐ Hard ☐ Pebbles/balls

What is the color of your child's stool? ☐ Brown ☐ Yellow ☐ Green ☐ Orange ☐ Red ☐ Black

Parent/Patient Signature _____ Date _____

Physician Signature _____ Date _____

Race and Ethnicity Information

We want to make sure that all our patients get the best care possible. We would like you to tell us your child's racial and ethnic background as well as your preferred language so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. You may decline to answer if you wish.

The only people who see this information are registration staff, administrators for the practice, your care providers, and the people involved in quality improvement and oversight, and the confidentiality of what you say is protected by law.

Please mark the appropriate response:

Primary Language

- ☐ Albanian
- ☐ American Sign Language
- ☐ Arabic
- ☐ Armenian
- ☐ Bengali
- ☐ Bosnian
- ☐ Cantonese (Chinese)
- ☐ Creole
- ☐ Croatian
- ☐ ECH
- ☐ Danish
- ☐ English
- ☐ French
- ☐ German
- ☐ Greek
- ☐ Hebrew
- ☐ Hindi
- ☐ Indonesian
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Latin
- ☐ Malay
- ☐ Mandarin (Chinese)
- ☐ Persian
- ☐ Polish
- ☐ Portuguese
- ☐ Romanian
- ☐ Russia
- ☐ Serbian
- ☐ Slovak
- ☐ Spanish
- ☐ Swahili
- ☐ Swedish
- ☐ Tagalog
- ☐ Thai
- ☐ Turkish
- ☐ Urdu
- ☐ Vietnamese
- ☐ Yiddish
- ☐ Yugoslavian
- ☐ Other
- ☐ Declined
- ☐ Unknown

Race

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Island
- ☐ White
- ☐ Other Combination Not Described
- ☐ Declined

Ethnicity

- ☐ Hispanic or Latino or Spanish Origin
- ☐ Not Hispanic or Latino or Spanish Origin
- ☐ Declined

Pharmacy Information

So that you and your physician may take advantage of e-prescribing, we need you to provide information on the pharmacy that you choose to use to fill you or your child's prescriptions. Electronic prescription requests are more efficient, accurate and cost effective. Feel free to speak with your physician if you have additional questions.

☐ New

Date:

Patient Name:

NYH #:

PRIMARY
Pharmacy Name:

Address:

Phone Number:

Fax Number:

SECONDARY (if applicable)
Pharmacy Name:

Address:

Phone Number:

Fax Number:
