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

FOLLOW UP VISIT 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:

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

A. Current Medical History

1) List all medications (include over the counter and herbal therapies).

Current Medications	Dose	How often

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

3. Drug/Medication Allergies: _____ Food Allergies: _____

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

5. List any **RECENT** 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
- ☐ Seizures
- ☐ Mental retardation/developmental delay
- ☐ Asthma, Emphysema
- ☐ Cystic Fibrosis
- ☐ Sickle cell disease or trait
- ☐ Cancer (list type)
- ☐ High blood pressure
- ☐ Heart disease or stroke
- ☐ Diabetes
- ☐ Anemia
- ☐ High cholesterol
- ☐ Constipation
- ☐ Polyps
- ☐ Gallstones/ gall bladder problem
- ☐ Gastritis/ulcer
- ☐ Colitis, Crohn's disease
- ☐ Celiac disease
- ☐ Liver problems
- ☐ Blood in stool
- ☐ Irritable bowel syndrome

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

C. Social History: (ANY RECENT CHANGES)

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
- ☐ Ear infections
- ☐ Nasal congestion
- ☐ Bloody nose
- ☐ Mouth sores/ulcers

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
- ☐ Apnea (stops breathing)
- ☐ Asthma
- ☐ Pneumonia

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)

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

☐ Trouble swallowing
☐ Dental problems
☐ Sour taste in mouth
☐ Hoarseness

Skin
☐ Rash
☐ Hair loss
☐ Eczema

Breasts
☐ Nipple discharge
☐ Breast lumps/masses

Genital/Urinary System
☐ Increased urine frequency
☐ Urgency
☐ Urinating at night
☐ Blood in urine
☐ Pain with urination

Hematology/Blood
☐ Easy bleeding
☐ Easy bruising
☐ Anemia
☐ Thalassemia
☐ Received blood transfusions

☐ Genital lesions
☐ Absent periods
☐ Menstrual problems
☐ Age at first menstrual period _____
☐ Date of last menstrual period _____

☐ Swollen lymph nodes
☐ Bleeding problem/disorder

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

Allergy/Immune systen
☐ Hives
☐ Anaphylaxis
☐ Lip swelling
☐ Skin feels tight
☐ Morning stiffness
☐ Raynaud's syndrome
☐ Frequent infections
☐ Unusual infections

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

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

E. Feeding History:

Is your child's appetite normal, increased or decreased? _____

F. Stooling history:

How often does your child stool now?

When was your child's last bowel movement?

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

Is your child's stool malodorous (smells 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 _____

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.

☐ Update

Date:

Patient Name:

NYH #:

PRIMARY
Pharmacy Name:

Address:

Phone Number:

Fax Number:

SECONDARY (if applicable)
Pharmacy Name:

Address:

Phone Number:

Fax Number:
