Stephen C. Fiedorek, M.D.
Pediatric Gastroenterology and Nutrition Database (2 years & older)
The Pediatric Clinic, P.A.
1525 Country Club Road
Sherwood, AR 72120
(For children 2 years and older).

Dr. Fiedorek requests that this database be completed to provide him an in depth understanding of your child's past health and background. After reviewing the database, he will be able to discuss your child's current problems, as well as the information you have provided on this form, in detail with you. Please return to office or fax to 501.819.6171.

Today's Date: _____

Full name of child: _____

Name child prefers to be called: _____ Date of Birth: _____

Referring physician / telephone: _____

Name and relationship to child of the person providing the information on this form:

_____

Reason(s) for evaluation:

_____

_____

_____

Medications:

Please list any prescription medications, over-the-counter medications, herbs, or supplements that are currently used. Include the doses when known. None: _____

_____

_____

_____

Allergies:
Please list any drug, food, and inhaled allergies with type of reactions. None: _____

_____

_____

Has your child used tobacco (smoke, chew, snuff)? Please circle: never current daily user some daily use former unknown, but concerned

Review of Systems:

Please **circle** any of the following symptoms your child may have **at the present time** and describe briefly below.

General: fever, low energy level, fatigue, overweight, underweight

Endocrine: weight gain, weight loss, growth delay, short stature

Eyes: redness, pain, drainage, vision problems

Ears: pain, drainage, hearing loss

Nose: congestion, drainage, bleeding, sinus pain

Mouth/Throat: oral ulcers, tooth pain, sore throat, hoarse voice, aspiration, swallowing difficulties

Respiratory: cough, congestion, wheezing, apnea, breathing difficulties, asthma

Heart: murmurs, chest pain, palpitations

Gastrointestinal: abdominal pain, feeding problems, swallowing problems, appetite changes, spitting up, vomiting, diarrhea, constipation, painful bowel movements, incontinence, blood in the stool, bloating, gas, burping

Genitourinary: hernia, frequent urination, painful urination, brown urine, back pain, leaking urine

Musculoskeletal: joint swelling, tenderness, redness, muscle weakness, stiffness

Skin: rashes, jaundice, eczema

Hematologic: bleeding, anemia, swollen glands, puffy eyes, swollen feet / hands

Allergic/Immunologic: hives, frequent respiratory / gastrointestinal / skin infections

Neurologic: seizures, dizziness, fainting, cerebral palsy, developmental delay

Psychiatric: mood changes, sleep problems, depression, aggressive behavior, defiant behavior

Other symptoms: _____

_____

_____

_____

Past Medical History:

Newborn/Birth/Pregnancy History:
List any problems with pregnancy, labor, delivery, or early newborn period. None: _____

_____

_____

Past Medical/Surgical History:
Please briefly describe any previous or ongoing medical problems that your child has had.

None: _____ _____

_____

_____

_____

Please list any hospitalizations with brief summaries and dates. None: _____

_____

_____

Please list any operations with dates. None: _____

_____

_____

Immunization History:

_____ Up to date

_____ If your child is missing any immunizations, please note the reason(s) why.

_____

Development History:
Please describe any previously diagnosed developmental or behavioral problems and any concerns you may have regarding your child's development. None: _____

_____

_____

Please list the following with telephone number, if applicable.

Psychologist / Counselor: _____

OT Provider: _____

PT Provider: _____

ST Provider: _____

If applicable, please complete the following section.

Menstrual History:

Age at onset of menstrual periods: _____

Starting date of last menstrual period: _____

List any problems with monthly menstrual cycle. None: _____

_____

List any medications used to alleviate any problems.

_____

Nutrition and Diet History:
Please briefly describe your child's typical diet.

_____

_____

_____

List any dietary restrictions. None: _____

_____

_____

List type and quantity of dairy products consumed on average daily or weekly. None: _____

_____

Please estimate number of servings of the following foods consumed per week.

_____ Fruits
_____ Vegetables
_____ Whole grain breads, crackers, pasta, brown rice
_____ Cereal (list type _____)
_____ Cooked beans (for example, pinto, navy, kidney, refried, red, black, split peas, lentils, purple hull peas, black-eyed peas)
_____ Caffeinated tea or coffee
_____ Caffeinated soft drinks
_____ Decaffeinated soft drinks, tea, coffee
_____ Energy drinks
_____ Sports drinks (Gatorade, Powerade, etc.)
_____ Juice
_____ Chocolate
_____ Peppermints

If your child's weight concerns you because it is too high, please complete the following.
Describe previous or ongoing attempts to assist your child to lose weight.

_____

_____

_____

Please complete this page only if your child has extraordinary feeding requirements.

Please check below all methods currently used to feed your child.

_____ Oral formula feedings

Formula type and additives: _____

Special supplies: _____

Other: _____

_____ Combination oral and tube feedings

_____ Tube feedings only

If tube feedings are used, circle all applicable:

G-tube J-tube Nasogastric tube Nasojejunal tube

If type and size of tube is known, please list: _____

_____ Continuous feedings:

Type of formula: _____

Duration: _____ Rate: _____

_____ Bolus/gavage feedings:

Type of formula: _____

Volume of formula/water: _____

Frequency: _____

_____ TPN

List home health provider for formula or medical equipment.

_____ Telephone: _____

List home health agency for home nursing care.

_____ Telephone: _____

Family history:

Please list any illnesses or significant medical conditions that the following relatives have.

Mother (current age _____)

_____

Father (current age _____)

_____

Siblings (sex, current age) _____

_____

Grandparents

_____

Parent's siblings

_____

Please note any relatives of your child that have any of the following specific conditions.

Digestive disorders _____

Celiac disease _____

Food allergies _____

Irritable bowel syndrome _____

Chronic/recurrent diarrhea _____

Constipation _____

Liver disease_____

Gallstones _____

Gastroesophageal reflux _____

Ulcers _____

Thyroid problems _____

Autoimmune illnesses: Lupus, psoriasis, Crohn's disease, ulcerative colitis, arthritis, fibromyalgia, chronic hepatitis, dermatomyositis, ankylosing spondylitis

_____

Colon polyps _____

Colon cancer _____

Social/Environmental History:

Child resides with (please circle):
both parents mother father adopted parent(s) guardian foster parent(s)

Marital status of parents: married divorced separated widowed remarried single

Languages other than English spoken in the home: _____

Religious affiliation: _____

Childcare arrangements (check all that apply):

_____ At home full time

_____ Daycare (in-home center-based)

_____ School

_____ After school care

_____ Meals provided at daycare or school (please list): _____

Name of school: _____ Grade: _____

Extracurricular activities: _____

Hobbies/employment: _____

During the past 6 months:
Has your child traveled out of state? If so, where? _____

Could your child have drunk untreated river, lake, or well water? _____

Has your child used alcohol? _____ Has your child used illicit drugs? _____

Please check if your child has been physically near to any of the following and describe.

_____ People with contagious illnesses_____

_____ Pets that are sick _____

_____ Farm animals _____

_____ Birds, reptiles _____

_____ Second hand smoke _____

Contact information:

Home telephone: _____ Mobile telephone: _____

Other telephone: _____ E-mail (if desired): _____

Pharmacy / telephone: _____

Date reviewed by physician: _____ Physician's signature: _____