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 by email to ginurse@thepediatric.com or fax to 501.819-6171. If you have any questions please contact us at 501.758.1530.

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 check:

never current daily user some daily use former unknown, but concerned

Review of Systems:

Please check 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 ( )
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, check 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

Ulsers

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 check):

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:** ______________________________