Stephen C. Fiedorek, M.D.
Pediatric Gastroenterology and Nutrition (less than 24 months)
The Pediatric Clinic, P.A.
1525 Country Club Road
Sherwood, AR 72120

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.**

Pediatric Gastroenterology and Nutrition Database

For children less than 24 months. Today's Date: _____

Full name of child: _____

Name child prefers to be called: _____

Date of Birth: _____

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

_____

Contact information:

Home telephone: _____ Mobile telephone: _____

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

Pharmacy / telephone: _____

Referring physician / telephone: _____

Reason(s) for evaluation:

_____

_____

_____

_____

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

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

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

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: irritability, sleep problems, depression, aggressive behavior, defiant behavior

Other symptoms: _____

_____

_____

_____

Past Medical History:

Newborn/Birth/Pregnancy History:

Mother's age at the time of delivery: _____

Prenatal care: Yes No

Number of mother's previous pregnancies: _____

Number of mother's living children including the patient: _____

Mother's health problems during pregnancy (if any): _____

Please note any abnormal laboratory or diagnostic tests during pregnancy:

_____

Medications mother received: _____

Labor: list any complications: _____

Type of Delivery: vaginal C-section forceps vacuum

Apgar score, if known: _____

Newborn period:

Birth weight: _____ Gestational age: _____

Duration of hospitalization: _____

Name of hospital: _____

Any complications or problems: 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 brief summaries and dates. None: _____

Allergies:

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

Medications:

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

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: _____

Immunization History:

_____ Up to date

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

_____

Nutrition and Diet History:
Breast-fed: Yes No
Age at weaning: _____
If any problems related to breast-feeding have been present, please describe. None: _____

_____

_____

If currently bottle-fed, list the type(s) of formula used (birth to present or weaning to present).

_____

_____

Current formula type: _____

Quantity per feeding: _____

Feeding schedule: _____

List any dietary restrictions. None: _____ _____

Please estimate number of servings of the following per week (or ounces per 24 hours).
_____ Caffeinated soft drinks / tea
_____ Decaffeinated soft drinks / tea
_____ Energy drinks
_____ Sports drinks (Gatorade, Powerade, etc.)
_____ Juice
_____ Chocolate
_____ Peppermints

Please complete this page only if your child has <u>extraordinary</u> feeding requirements.

Please check all methods currently used to feed your child.

_____ Oral formula feedings
Type of formula: _____

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 GJ-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 ages_____)

_____

_____

Grandparents

_____

_____

Parent's siblings

_____

_____

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

Digestive disorders _____

Irritable bowel syndrome _____

Chronic/recurrent diarrhea _____

Constipation _____

Celiac disease _____

Food allergies _____

Liver disease_____

Gallstones _____

Gastroesophageal reflux _____

Ulcers _____

Autoimmune illnesses:

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

_____

Colon polyps _____

Colon cancer _____

Thyroid problems _____

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)

_____ Meals provided at daycare (please list): _____

Please check if your child recently 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 _____

During the past 6 months:

Has your child traveled out of state? If so, where? _____

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

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