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Pediatric Gastroenterology and Nutrition (less than 24 months)
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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. Please contact us at 501-758-1530 if you have any questions.**

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 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 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

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:

Mothers 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 extraordinary 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, check 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:

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 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)

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: _____