PEDIATRIC GASTROENTEROLOGY AND NUTRITION CLINIC FOLLOW UP

NAME: ______________________________ PHONE #:____________________ PRIMARY DOCTOR: ______________

PHARMACY: _________________________ E-MAIL____

PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS YOUR CHILD HAS OR HAS HAD RECENTLY

GENERAL	**YES**	**NO**	**HEAD**	**YES**	**NO**
Tiredness			Frequent sore throat or hoarseness		
Fever			Frequent cavities		
Decreased activity			Visual or hearing problems		
Decreased appetite			Frequent ear or sinus infections		
Missing school			Mouth sores		
Poor weight gain/weight loss			Frequent congestion/runny nose		
Excessive weight gain			Retching/gagging/choking		
Poor sleeping			Pain or trouble swallowing		
Irritability/Increased crying			Food getting stuck after swallowing		

CHEST	**YES**	**NO**	**NERVOUS SYSTEM**	**YES**	**NO**
Stopped breathing			Seizures		
Turned blue			Depression		
Shortness of breath			Change in personality		
Cough			Anxious		
Wheezing			Headache		
Pneumonia			Difficulty with school		
Bronchitis			Dizziness		
Chest pain					

GASTROINTESTINAL	**YES**	**NO**	**KIDNEYS/BLADDER/REPRODUCTION**	**YES**	**NO**
Abdominal bloating			Pain on urination		
Abdominal pain			Frequent urination		
Nausea			Blood in urine/Dark urine		
Vomiting			Irregular or painful periods		
Diarrhea			Discharge from penis or vagina		
Constipation			**BONES/MUSCLES/JOINTS**		
Vomiting blood			Joint pain		
Blood in the stool			Joint swelling		
Black stool			Back pain		
Pale stool			**SKIN**		
Excessive burping			Rash		
Excessive gas			Bruises or bleeds easily		
Regurgitation			Eczema		

MEDICATIONS CURRENTLY TAKING:____

DIET: ____

ALLERGIES TO MEDICATIONS: (Please list medications and reactions):

____

CHANGES IN FAMILY MEDICAL OR SOCIAL HISTORY:

____

Signature: ____________Relationship to child: ________Date: ________ Revised 12/09