



PEDIATRIC
GASTROENTEROLOGY
SPECIALISTS OF MARYLAND

6816 Deerpath Rd, Suite 205, Elkridge, MD 21075

P 443-539-8338 f 410-796-6111

Date: _____

DOB: _____

Name: _____
Last First MI

Address:

_____ Street City

_____ State Zip

Primary Phone: _____ Home/Cell/Work

Secondary Phone: _____ Home/Cell/Work

Sex: Male Female Race: _____ Age: _____

Primary Care Physician: _____

Referring Provider: _____

Referring provider practice name, phone #, fax #: _____

Pharmacy: _____

Pharmacy phone #, fax #: () - - () - -

How did you learn of Pediatric Gastroenterologists of Maryland? _____

HISTORY OF PRESENT ILLNESS

What is the main problem for which your child is seeking treatment? _____

When was the first occurrence of this problem? _____

What has been done to treat/evaluate the presenting problem in the past? Circle all that apply.

Blood work/labs X-Ray MRI/CT Other testing

Date and Results of each:

BIRTH HISTORY

How was child delivered? _____

Was child born at full term or premature? Circle.

Term Premature: how early? _____

Did the child experience any problems at birth or infancy (ex. went to special care nursery or NICU)? If yes, explain.

Age when child passed first stool/meconium (tarry black stool): _____

PAST MEDICAL HISTORY

Already diagnosed conditions: _____

Hospitalizations: _____

Surgeries: _____

Nutrition including any dietary restrictions: _____

Immunizations: _____

Meds (OTC and herbals) doses and frequency: _____

Allergies: _____

SOCIAL HISTORY

Development: Grade _____ Problems in school? _____

With whom does the child live, any contact with animals or pets, any recent travel outside the US or visitors from other countries, toxin exposure? _____

Females: Age at 1st period, Date of last period, pregnant? _____, _____, Yes No

FAMILY HISTORY

Mother's medical health: _____

Father's medical health: _____

Biological siblings medical health: _____

Any other family members with medical problems and what (esp. Crohns disease, ulcerative colitis, celiac, food allergies, GI polyps, etc.) _____

REVIEW OF SYSTEMS (circle all that apply for each)

General: problems with appetite, problems with weight, problems with sleeping, problems with energy, problems with fevers

Head, Ears, Eyes, Nose, Throat: blurry vision, double vision, abnormal nosebleeds, post nasal drip, frequent canker sores in mouth, trouble swallowing or choking, frequent ear infections

Respiratory: cough, wheezing, difficulty breathing

Cardiac: chest pain, heart murmur

Gastrointestinal: abdominal pain, nausea, vomiting, constipation, diarrhea, bloating, blood in stools

Urinary: painful urination, blood in urine, bedwetting

Muskuloskeletal: joint pain, joint swelling

Neurological: headaches, balance problems, dizziness, fainting, seizures, behavioral issues

Skin: Rashes, easy bleeding/bruising, itching, jaundice

Other: Anemia, thyroid disease or diabetes

Please tell us anything else that you feel is important for us to know:
