Patient name:	Primary care doctor:
Date of birth:	Preferred pharmacy:

Swedish Pediatric Gastroenterology Intake Form (Age under 2 years)

Patient's MAIN Symptom	
Symptom duration	❑____days ❑ ____weeks ❑ _____months ❑ ____years
Symptom frequency	❑Occasional ❑Frequent ❑ All the time
Most frequent time of day	❑Random ❑ After food ❑ Upon waking ❑Evening ❑ Overnight ❑ Other: _____
Symptom interferes with	❑ Sleeping ❑ Eating ❑ Playing
Symptom worsened by	❑Dairy ❑Sweet food ❑Entire meals ❑Lying down ❑ Moving around ❑Other: _____
Symptom improved by	❑Food ❑ Rest ❑ Bowel movements ❑Medication: _____ ❑ Other: _____
Food eliminations tried	
Birth History	❑Full Term ❑Pre-term _____weeks ❑Birthweight: _____ ❑Vaginal delivery ❑ C-section ❑Pregnancy or delivery problems_____ ❑Problems in nursery_____ ❑Did NOT pass a stool in the first 2 days of life
Dietary History	❑Breast milk ❑Formula _____(brand) ❑Solids introduced? _____(age) ❑Reactions to food/formula/milk _____

Other Complaints			Current Medications
❑ Abdominal pain	❑ Diarrhea	❑ Weight loss _____(lb)	
❑ Vomiting	❑ Constipation	❑ Poor weight gain	
❑ Retching/dry heaving	❑ Blood in the stool	❑ Fevers	
❑ Excessive belching	❑ Mucous in the stool	❑ Joint pain/swelling	
❑ Excessive spitups	❑ Painful stools	❑ Rashes	
❑ Bloating	❑ Urgent stools	❑ Sick family members	
❑ Anxiety	❑ White/pale stools	❑ Yellow skin or eyes	**Allergies**
❑ Excessive crying	❑ Trouble swallowing food		

Family History	Social History	Past Surgeries or Medical Issues
❑ Crohn's disease	❑In Daycare	
❑ Ulcerative colitis	❑Siblings: Ages_____	
❑ Celiac disease	❑**Parent 1** Name_____	
❑ Juvenile "insulin-dependent" diabetes	Occupation _____	
❑ Thyroid disease	❑**Parent 2** Name_____	
❑ Auto-immune disease (Lupus, psoriasis, rheumatoid arthritis, etc.)	Occupation_____	
❑ Liver disease	❑Parents live together?	
❑ Other: _____	❑Recent travel to undeveloped country	
	❑Using WIC for child's nutrition?	

For office use: Wt. Ht. Temp. HR BP