



**Patient History Form**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Reason for today's visit? \_\_\_\_\_

Please list current medications and dose: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What medications have your child tried and the dose?

- Prilosec/Omeprazole \_\_\_\_\_  Pepcid/Famotidine \_\_\_\_\_  Nexium/Esomeprazole \_\_\_\_\_
- Pantoprazole \_\_\_\_\_  Miralax \_\_\_\_\_  Senna \_\_\_\_\_  Ex-lax \_\_\_\_\_
- Other \_\_\_\_\_

Does your child have any allergies?  Yes  No To what? \_\_\_\_\_

Has your child ever had surgery?  Yes  No Why? \_\_\_\_\_

Any reactions to anesthesia?  Yes  No

Does Mercy Kids GI see any family member?  Yes  No Who? \_\_\_\_\_

**Review of Systems**

*Please check all that apply to patient only.*

**Gastrointestinal**

- Diarrhea
- Constipation
- Heartburn
- Trouble swallowing
- Nausea
- Abdominal Pain
- Other: \_\_\_\_\_

**Genitourinary**

- Kidney disease
- Frequent urine infections
- Other: \_\_\_\_\_

**Cardiac**

- High BP
- Low BP
- Irregular heartbeat
- Chest pain
- Other: \_\_\_\_\_

**Endocrine/Metabolic**

- Diabetes
- Thyroid Disorders
- Other: \_\_\_\_\_

**Respiratory**

- Asthma
- Chronic cough
- Hoarseness
- Pneumonia
- Tracheotomy
- Other: \_\_\_\_\_

**Neurological**

- Seizures
- Weakness
- Migraines
- Stroke
- Other: \_\_\_\_\_

Any other symptoms/disease not listed: \_\_\_\_\_  
 \_\_\_\_\_

**Ear, Nose Throat**

- Chronic ear infections
- Chronic throat infection
- Other: \_\_\_\_\_

**Family History Conditions**

	Yes	No	Relation to Patient
Colon/Rectal Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anesthesia problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colon polyps	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Social History**

Who does the child live with? \_\_\_\_\_  
 How many siblings? \_\_\_\_\_  
 Does your child have trouble with school? \_\_\_\_\_

Other illness in immediate family members: \_\_\_\_\_

Pharmacy name/number: \_\_\_\_\_

Person completing form/relation to patient: \_\_\_\_\_