

Office Use Only

VFC: [] MDD/DKC
[] Native
[] NO Insurance
[] Not Eligible
INSURANCE Notes



Abdominal Pain / Constipation / Blood in Stool

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WT: _____ lb
_____ kg
Temp: _____
Pain Scale: _____

Child's name: _____

Child's birthday: _____

Specific Reason for Visit: _____

Symptoms

Abdominal pain yes/no. If yes, how long? _____
Constipation yes/no. If yes, how long? _____
Hard stools? yes/no. _____
Stool "accidents"? yes/no _____
Blood in stool? yes/no. If yes, how long? _____
Stooling frequency: _____
How much water does your child drink daily? _____
Is your child a picky eater? Yes/no.

Review of systems:

Fever yes/no. If yes, how long? _____
Decreased appetite yes/no. If yes, how long? _____
Heartburn yes/no. If yes, how long? _____
Vomiting yes/no. If yes, how long? _____
Diarrhea yes/no. If yes, how long? _____
Urinary symptoms yes/no. If yes, how long? _____
Dry skin yes/no. If yes, how long? _____
Rash yes/no. If yes, how long? _____
Joint pain yes/no. If yes, how long? _____
Sleep problems yes/no. If yes, how long? _____

Does your child have any chronic medical problems? Yes/no. If yes, please explain. _____

Is your child taking any daily prescribed medications? Yes/no. If yes, please explain. _____

Does your child have a medication allergy? Yes/no. What medication/reaction? _____

Has your child been admitted to the hospital overnight? Yes/no. If yes, please explain. _____

Does your family have any pets? Yes/no. please circle: dog/cat/other _____

Has your child had any surgeries? Yes/no. If yes, please explain. _____

Does anyone in the family have:

Esophageal reflux/peptic ulcer disease? Yes/no please circle: father/mother/sibling/grandparent
Crohn's disease or ulcerative colitis? Yes/no please circle: father/mother/sibling/grandparent
Malnigancy of the gastrointestinal tract? Yes/no please circle: father/mother/sibling/grandparent

Does anyone in the family smoke? Yes/no.

Does your child attend daycare / preschool / school? (please circle) What grade in school? _____

Are your child's immunizations up-to-date? Yes/no. If no, please explain. _____

Has your child used the followed "over the counter" or prescribed treatments for constipation: (please circle)

Enemas, glycerin or other suppositories, lactulose, mineral oil, Miralax, other

This form completed by: _____ Relationship to Child: _____