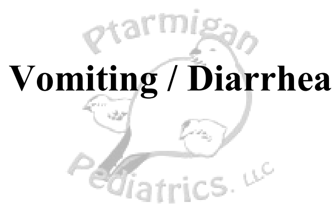
Office Use Only

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

INSURANCE Notes



Vomiting / Diarrhea

Child's name: ____________________

Child's birthday: ____________________

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WT: ______________lb
______________ kg
Temp: ______________
Pulse: ______________
Respirations: __________
Pain Scale: ____________

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
Malignancy 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: ____________________