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

Swedish Pediatric Gastroenterology Intake Form (Age 2 and up)

Patient's MAIN Symptom	
Symptom duration	❑____days ❑ ____weeks ❑ _____months ❑ ____years
Symptom location	
Symptom frequency	❑Occasional ❑Frequent ❑ All the time
Most frequent time of day	❑Random ❑ After food ❑ Upon waking ❑Evening ❑ Overnight ❑School ❑ Other: _____
Symptom interferes with	❑ School ❑ Sleep ❑ Meals ❑ Play
Symptom worsened by	❑Dairy ❑Sweet food ❑Meals ❑Lying down ❑ Activity ❑Other: _____
Symptom improved by	❑Food ❑ Rest ❑ Bowel movements ❑Medication: _____ ❑ Other: _____
Food eliminations tried	

Other Complaints			**Current Medications**
❑ Abdominal pain	❑ Diarrhea	❑ Weight loss _____(lb)	
❑ Nausea	❑ Constipation	❑ Fevers	
❑ Vomiting	❑ Blood in the stool	❑ Joint pain/swelling	
❑ Retching/dry heaving	❑ Mucous in the stool	❑ Rashes	
❑ Excessive belching	❑ Painful stools	❑ Sick family members	
❑ Excessive spitups	❑ Painful urination	❑ Reactions to food	
❑ Abdominal bloating	❑ Stool leakage	❑ Bloating	
❑ Chest pain	❑ Urinary leakage	❑ Excessive crying	
❑ Heartburn	❑ Urgent stools	❑ Yellow skin or eyes	**Allergies**
❑ Anxiety, low mood, or excessive stress	❑ White/pale stools	❑ Trouble swallowing food	

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

For office use: Wt. Ht. Temp. HR BP Oct.2015