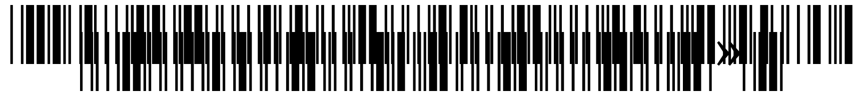
Children's
of Alabama
1600 7th Avenue South
Birmingham, AL 35233



Admit Date: «AdmitDate» ECD #: «PatientNumberText»
«PatientName»
MR#: «MedicalRecordNumber» EP: «Location» «Room» «Bed»
DOB: «BirthDate» Age:«Age»«AgeCode» Sex:«Gender» Race: «Race»
Attending Dr: «AttendingDoctorName» Dr.#:«AttendingDoctorNumber»
Referring Dr: «ReferringDoctorName» «ReferringDoctorLocation»

GI Clinic Patient Intake History – Completed by Parent or Patient

Please complete at every visit, except as noted.

Patient's Preferred Name	Parent Preferred Phone Number	Parent Email
Name of Person with Patient Today	**Relationship to Patient**	**Referring Physician**
Pharmacy Name	**Pharmacy City/Street**	**Pharmacy Phone Number**

Main Concern

What is your main symptom or concern you would like to discuss today? ____

How long: □ ____days □ _____weeks □_____ months □_____ years

How often: □ sometimes □ daily □ always

What time of day: □ upon waking □ daytime □ evening □ after eating □ at night □ random

Symptoms interfere with: □ eating □ sleeping □ school activities

Tell us about the patient's bowel movements if having constipation or diarrhea, otherwise can skip

How often: ______ times per day OR every _____ days

How do they look: □ hard □ lumpy □ smooth and formed □ soft □ loose □ watery

Blood in stool or after wiping: □ never □ sometimes □ daily □ always

Diet

□ Breastmilk □ Formula: ____________________________ □ Regular for age □ Other: _________________________________

If Breastmilk or Formula: Ounces per feeding: ________ Feedings per day: _______

Feeding Type: □ By mouth □ NG-tube □ G-tube □ GJ-Tube □ other: ________________ Tube size: ______ FR ______ cm

If tube fed, administered by: □ Gravity □ Pump If "pump", rate: _____ mLs\hr (milliliters per hour) □ Water flush _________ mL

Volume per feeding: ________ Feedings per day: ________ or Continuous

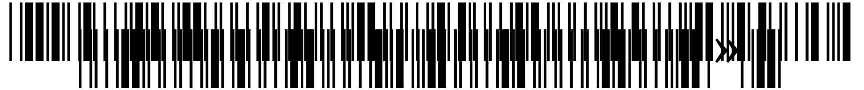
Current Medications □ **NONE**

Medication (prescriptions, over the counter, natural/herbal)	Dose/Concentration	How many times per day?

Allergies □ **NONE**

Medication, Food, Environmental Allergies	Reaction

1600 7th Avenue South
Birmingham, AL 35233



Admit Date: «AdmitDate» ECD #: «PatientNumberText»
«PatientName»
MR#: «MedicalRecordNumber» EP: «Location» «Room» «Bed»
DOB: «BirthDate» Age:«Age»«AgeCode» Sex:«Gender» Race: «Race»
Attending Dr: «AttendingDoctorName» Dr.#:«AttendingDoctorNumber»
Referring Dr: «ReferringDoctorName» «ReferringDoctorLocation»

Other symptoms (Currently having or since last GI visit) □ **NONE**

□ Poor appetite	□ Constipation	□ Easy Bleeding or bruising	□ Chest pain
□ Nausea	□ Painful stools (poop)	□ Headaches	□ Irregular heart beat
□ Vomiting	□ Soiling or stool accidents	□ Chills or night sweats	□ Urine (pee) accidents
□ Trouble swallowing	□ Blood in stool	□ Mouth sores	□ Painful urination
□ Heartburn	□ Weight loss	□ Achy joints	□ Feeling dizzy
□ Abdominal pain	□ Poor weight gain	□ Red or swollen joints	□ Fainting
□ Burping more than usual	□ Yellow eyes	□ Rash	□ Irregular periods
□ Gas or bloating	□ Chronic/unexplained fever	□ Bigger lymph nodes	□ Anxiety or stress
□ Diarrhea	□ Low energy/feeling tired	□ Wheezing	□ Depression

Birth History if under 2 years of age, otherwise can skip

Birth weight: _____ lbs _____ oz Born at: □ Full term (37-42 weeks) □ Premature (before 37 weeks) _____ weeks

Other Known Health Problems: □ **NONE** □ **No changes since last GI visit**

____	____
____	____
____	____
____	____

Past Hospital Stays: □ **NONE** □ **No changes since last GI visit**

Reason	Date (month/year)	Hospital
____	___________________	____________________________________
____	___________________	____________________________________
____	___________________	____________________________________

Past Surgeries: □ **NONE** □ **No changes since last GI visit**

Surgery	Date (month/year)	Hospital
____	___________________	____________________________________
____	___________________	____________________________________
____	___________________	____________________________________

Does any of your family members have any of these conditions? □ **NONE** □ **No changes since last GI visit**

M = Mother **S =** Sister **MGM =** Maternal Grandmother **MGF =** Maternal Grandfather
F = Father **B =** Brother **PGM =** Paternal Grandmother **PGF =** Paternal Grandfather

□ Allergic diseases ______________	□ Depression ______________	□ Liver disease ______________
□ Anesthesia reaction ______________	□ Diabetes ______________	□ Migraine headache ______________
□ Anxiety ______________	□ Esophagus dilation ______________	□ Overweight ______________
□ Asthma ______________	□ Food allergies ______________	□ Pancreatitis ______________
□ Celiac disease ______________	□ Heart disease ______________	□ Reflux disease ______________
□ Colon polyps ______________	□ GI cancer ______________	□ Stomach ulcer/H pylori ______________
□ Constipation ______________	□ High blood pressure ______________	□ Swallowing problems ______________
□ Crohn's disease ______________	□ High cholesterol ______________	□ Thyroid disease ______________
□ Cystic fibrosis ______________	□ Irritable bowel ______________	□ Ulcerative colitis ______________

Social History: □ **No changes since last GI visit**

Patient lives with: □ Both Parents □ Mother □ Father □ Grandparents □ Foster Parents □ Other _______________

Are natural parents separated and divorced? □ No □ Yes If "YES", when? ____________ Number of siblings: __________

School: __________________________ Grade: ________ How many missed school days this year? ____________________

School performance: □ Above Average □ Average □ Below Average Receives special education? □ No □ Yes

Activities/Hobbies/Sports: ____

Stressors: □ Recent move □ New school □ Difficulty making friends □ Family member with chronic illness
□ Death of family member □ Family financial problems □ Separation/Divorce of parents □ New sibling