# PMG AK Pediatric Gastroenterology Clinic

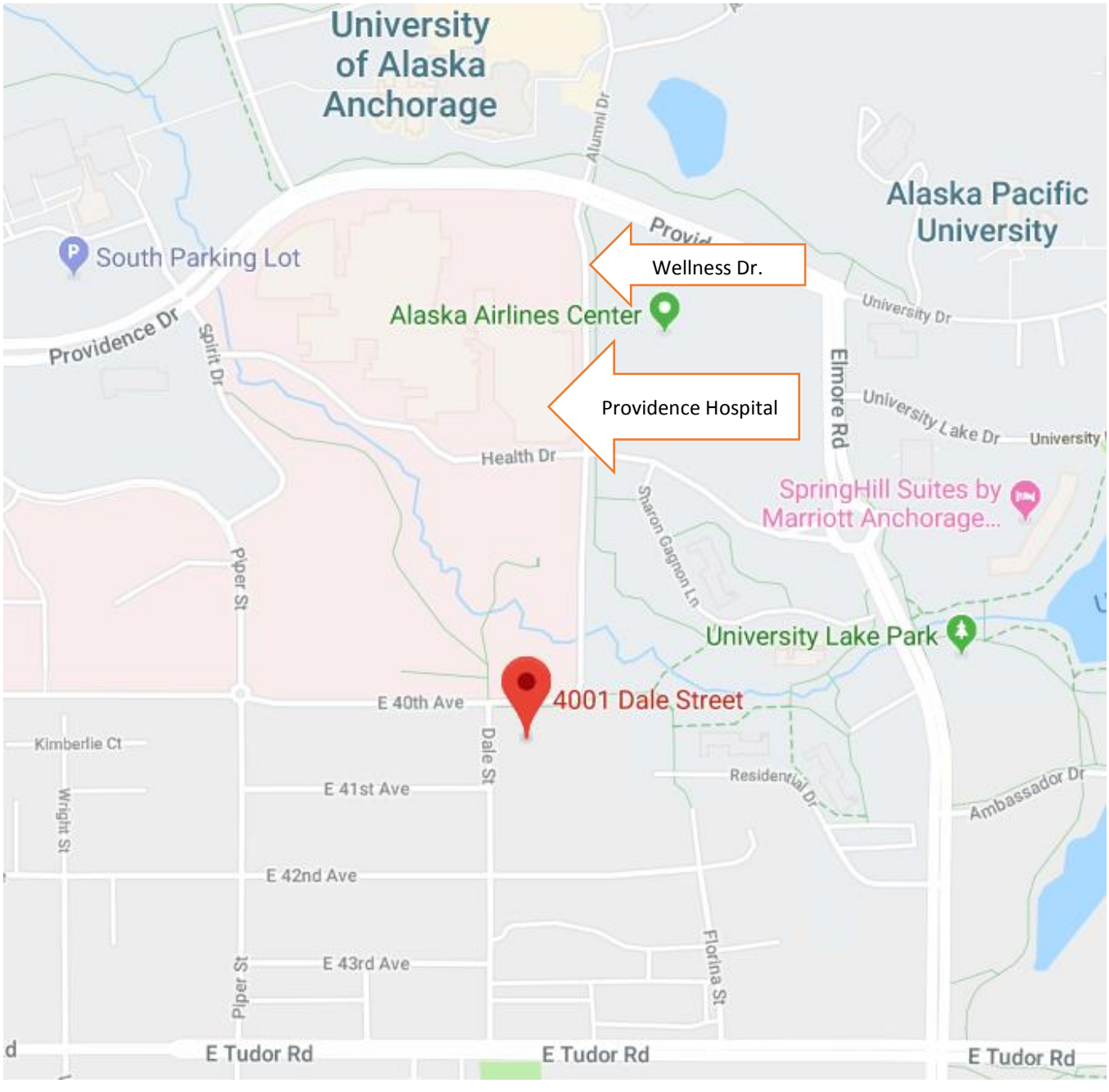
**4001 Dale St, Suite 201 Anchorage, AK 99508**
**Phone: 907-212-2240 Fax: 907-212-2872**

***Please fill out the attached paperwork and fax back to our clinic prior to your appointment.***

***Please do not mail completed paperwork to our office.***
***Please also bring your insurance card and parent/ guardian ID.***

**If you are a legal guardian or foster parent, you MUST bring in legal documentation to the appointment. If this is not provided the appointment will be canceled.**

***To avoid having to reschedule your appointment please arrive 15 min early.***



**Providence Pediatric Gastroenterology Clinic**
4001 Dale St, Suite 201 Anchorage, AK 99508
907-212-2240 Fax: 907-212-2872

**PATIENT REGISTRATION**

**PATIENT INFORMATION:**

Last Name: _____ First Name: _____ M.I.:_____

SSN: _____ DOB: _____ Gender: F / M

Address: _____ City _____ State ____ Zip _____

Race: _____ Ethnicity: □ Non-Hispanic □ Hispanic

**Primary Provider:** _____ Clinic: _____

**PARENT/GUARDIAN/RESPONSIBLE PARTY:** Who is legally responsible for the child?

Last Name: _____ First Name: _____ M.I.:_____

Marital Status: M / S / D SSN: _____ DOB: _____ Gender: F / M

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Relationship to Patient: □ Mother □ Father □ Step-Parent □ Foster Parent □ Guardian Other:_____

**PARENT/GUARDIAN/RESPONSIBLE PARTY:**

Last Name: _____ First Name: _____ M.I.:_____

Marital Status: M / S / D SSN: _____ DOB: _____ Gender: F / M

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Relationship to Patient: □ Mother □ Father □ Step-Parent □ Foster Parent □ Guardian Other:_____

**PRIMARY INSURANCE:**

Insurance Name: _____ Policy ID #_____

Policy Holder: _____ Relationship to Patient: _____

SSN: _____ Date of Birth: _____ Gender: F / M

Employer Name: _____

Address: _____ City: _____ Zip Code: _____

**SECONDARY INSURANCE:**

Insurance Name: _____ Policy ID #_____

Policy Holder: _____ Relationship to Patient: _____

SSN: _____ Date of Birth: _____ Gender: F / M

Employer Name: _____

Address: _____ City: _____ Zip Code: _____

**TRAVEL QUESTIONS:**

*In the past 21 days, have you traveled to/from Guinea, Liberia, or Sierra Leone? Or, in the last 14 days, have you traveled to/from the Republic of Korea or countries in or near the Arabian Peninsula?* **YES / NO**

*In the past 21 days, have you had close contact with someone traveling in Guinea, Liberia, or Sierra Leone who is ill? Or, in the last 14 days any close contact with someone traveling in the Republic of Korea or in/near the Arabian Peninsula who is ill?* **YES / NO**

# Providence Pediatric Gastroenterology Clinic

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## NEW PATIENT MEDICAL HISTORY

**Patient Name:** _____ **Date of Birth:** _____ **Gender:** F / M

**What name does your child prefer to be called:** _____

**Form Completed By:** _____ **Relationship to Patient:** _____

**What GI symptoms are we seeing your child for:** _____

_____

### ALLERGIES

☐ **No Known Allergies** List any allergies to medications, food, latex, or other products:

| Allergy: | Reaction: |
|---|---|
| | |
| | |
| | |

### MEDICATIONS

☐ **No Medications** Please list **ALL** medications, including vitamins/herbal supplements, medicated creams, over the counter:

| Medication Name: | Dose/How Much: (mg, mL, IU) | Times Per Day: | Reason For Taking: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Preferred Pharmacy Name:**_____ **Location:** _____

### BIRTH HISTORY

**Was your child:** ☐ Premature ☐ Full Term ☐ Late Length of pregnancy in weeks: _____

☐ Patient is adopted

### HOSPITALIZATIONS AND/OR PROCEDURES/SURGERIES

☐ **None** Please list any hospitalizations or procedures/surgeries your child has had:

| Reason for Hospitalization or Procedure/Surgery | Age | Reason for Hospitalization or Procedure/Surgery | Age |
|---|---|---|---|
| | | | |
| | | | |

### FEMALE PATIENTS

☐ **Not Applicable** **Age at first period:** _____ **When was your last period:** _____

### SOCIAL HISTORY

**Child lives with:** ☐ Mother ☐ Father ☐ Step-parent ☐ Foster Parent ☐ Adoptive Parents ☐ Guardian

☐ Siblings Number of Siblings: _____ **Does your child live in multiple households:** ☐ Yes ☐ No

| | Name | Age | Occupation |
|---|---|---|---|
| **Mother:** | | | |
| **Father:** | | | |

**Which family member(s) usually takes care of your child:** _____

**Does anyone living with your child smoke: Tobacco: ( )**Yes **( )**No **Marijuana: ( )**Yes **( )**No

**If yes, do they smoke inside the home: ( )**Yes **( )**No

**Does your child attend school or childcare: ( )**Yes **( )**No Grade: _____ School Name: _____

**Has your child missed any school due to this GI problem(s): ( )**Yes **( )** No If yes, how many days: _____

**(Over)**

**Patient Name:** _____

## REVIEW OF SYSTEMS

**In the PAST 6 MONTHS please check (√) the box your child has had any of the problems listed below:**

| | GENERAL | | GASTROINTESTINAL | | Muscle Weakness |
|---|---|---|---|---|---|
| | Decreased Activity / Energy | | Abdominal Pain | | **NEUROLOGICAL/PSYCHOLOGIC** |
| | Recurrent Unexplained Fever | | Bloody Stool | | ADD/ADHD |
| | Weight Gain– Abnormal | | Constipation | | Anxiety |
| | Weight Loss | | Diarrhea | | Autism |
| | Poor Appetite | | Feeding Issues | | Behavioral Problems |
| | **HEENT** | | Jaundice (Yellow Skin or Eyes) | | Depression |
| | Difficulty Swallowing | | Liver Disease | | Developmental Delays |
| | Chronic Ear Infections | | Spitting Up / Reflux | | Dizzy / Lightheadedness |
| | Chronic Nasal Congestion | | Vomiting | | Frequent or Recurring Headaches |
| | Chronic Sore Throat | | Vomiting Blood | | Mood Swings |
| | Hearing Loss | | **ENDOCRINE** | | Night Terrors |
| | Mouth Sores | | Diabetes | | School Problems |
| | Runny Nose | | Excessive Thirst | | Seizures |
| | Vision Problems Other Than Glasses | | Excessive Urination | | Significant Head Injury |
| | Watery Eyes | | Growth Problems | | Sleeping Difficulties |
| | **RESPIRATORY** | | Thyroid Disease | | **HEMATOLOGIC/LYMPH** |
| | Asthma | | **GENTOURINARY** | | Anemia |
| | Chronic/Recurrent Cough | | Blood in Urine | | Easy to Bleed |
| | Pneumonia / Bronchitis | | Bed Wetting | | Easy to Bruise |
| | Wheezing | | Painful Urination | | Swollen Lymph Nodes |
| | **CARDIOVASCULAR** | | Urinary Tract Infections | | **SKIN** |
| | Blood Pressure Issues | | Kidney Disease | | Acne |
| | Chest Pain | | Menstrual Problems | | Eczema |
| | Fainting | | **MUSULOSKELETAL** | | Pale Looking Skin |
| | Heart Disease | | Joint Pain | | Rash |
| | Irregular Heart Beat | | Joint Swelling | | **OTHER** |
| | Murmur | | Muscle Pain | | Anesthesia Complications |

**Please list any other chronic medical conditions / diagnosis your child may have:**

## FAMILY MEDICAL HISTORY

Does anyone in your child's **BIOLOGIAL FAMILY** have any of the following?
(**M**=Mother, **F**=Father, **S**=Sister, **B**=Brother, **GM**=Grandmother, **GF**=Grandfather, **A**=Aunt, **U**=Uncle)
**Please check (√) the appropriate box**

| | M | F | S | B | GM | GF | A | U | MOM SIDE | DAD SIDE | | M | F | S | B | GM | GF | A | U | MOM SIDE | DAD SIDE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Abdominal Pain | | | | | | | | | | | Hepatitis C | | | | | | | | | | |
| Cancer | | | | | | | | | | | Irritable Bowel Syndrome | | | | | | | | | | |
| Celiac Disease | | | | | | | | | | | Liver Disease | | | | | | | | | | |
| Colon Polyps | | | | | | | | | | | Lupus | | | | | | | | | | |
| Constipation | | | | | | | | | | | Migraine Headaches | | | | | | | | | | |
| Crohn's Disease | | | | | | | | | | | Nausea | | | | | | | | | | |
| Diarrhea | | | | | | | | | | | Pancreatitis | | | | | | | | | | |
| Food Allergies | | | | | | | | | | | Rheumatoid Arthritis | | | | | | | | | | |
| Food Intolerances | | | | | | | | | | | Swallowing Problems | | | | | | | | | | |
| Gallstones | | | | | | | | | | | Thyroid Disease | | | | | | | | | | |
| GI Bleeding | | | | | | | | | | | Ulcerative Colitis | | | | | | | | | | |
| Heartburn/Reflux | | | | | | | | | | | Ulcers | | | | | | | | | | |
| Helicobacter pylori | | | | | | | | | | | Vomiting | | | | | | | | | | |
| Hepatitis B | | | | | | | | | | | Anesthesia Complications | | | | | | | | | | |

**Any other medical problems not listed above:**