Stanford Children's Health
Bayside Medical Group

Medical Information Regarding Your Child

Please answer all pertinent questions to your child

Patient Name: ______________________________ **DOB/ Age:** ______________

Person filling up this questionnaire: ☐ Mother ☐ Father ☐ Other ____________________

Primary Physician/ Other MD: ____

Have you been seen by: ☐ PAMF ☐ Sutter ☐ UCSF ☐ Kaiser ☐ Other ______________

Reason of Visit: ____

Allergies to Medications / food / environmental:

Name: ______________________ Reaction: ______________________

Name: ______________________ Reaction: ______________________

Patient Medical History:

	Yes	No		Yes	No		Yes	No
Anemia			**Weight loss**			**Skin Rash**		
Celiac			Poor Appetite			Eczema		
Gallbladder Stones			Fatigue			Hives		
Constipation			Fever			**Asthma**		
Chronic Diarrhea			Nighttime sweating			Chronic Cough		
Crohn's disease			**Bladder/Kidney Infection**			Recurrent Pneumonia		
Stools Soiling			Urine accidents			**Diabetes**		
Food Intolerance			Kidney disease			Thyroid disease		
GERD			**Nosebleeds**			**Heart Disease**		
Hepatitis			Hearing Loss			Chest Pain		
Ulcerative Colitis			Recurrent Canker Sores			Blood Pressure		
Abdominal Pain			Recurrent Sinusitis			Dizziness		
Rectal Bleeding			Seasonal Allergy			**Depression**		
Nausea			**Seizure**			Anxiety		
Vomiting			Migraines			Suicidal		
Trouble swallowing			Headache			Eating Disorder		
Heartburn			Cerebral Palsy			Substance Abuse		
Bloating			**Bleeding Disorder**			Smoking		
Jaundice			**Joint Pain / Swelling**			Alchohol		
Eye Disease			Back Pain			**Irregular Menses**		

Surgical History:

	Yes	No		Yes	No		Yes	No		Yes	No
Appendectomy			Fundoplication			Liver Biopsy			ERCP		
Gallbladder			Colonoscopy			Hospitalization			If yes; what's for?		
G tube			Endoscopy			Other significant			I f yes, what?		

Family History:

Relationship	*Mother*	*Father*	*Sister*	*Brother*	*Mat Aunt*	*Mat Uncle*	*Pat Aunt*	*Pat Uncle*	*Mat Grd M*	*Mat grd F*	*Pat Grd M*	*Pat Grd F*	*Other*
Ulcerative Colitis													
Crohn's disease													
Colon Polyp													
Hepatitis													
Liver Disease													
Jaundice													

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Relationship	Mother	Father	Sister	Brother	Mat Aunt	Mat Uncle	Pat Aunt	Pat Uncle	Mat Grd M	Mat grd F	Pat Grd M	Pat Grd F	
Gallbladder Disease													
Celiac													
GERD													
Irritable Bowel Syndrome													
Constipation													
Ulcers													
H. Pylori													
Stomach /intestine / liver Cancer													
HIV													
Tuberculosis													
Food Allergy													
Asthma													
Skin disease													
Thyroid disease													
Diabetes Insulin Depend													
Blood disorder													
Autoimmune disease													
Psychiatry disease													
Other Significant													

Social History:

Are the Parents Separated? ☐ No ☐ Yes ☐ Other ____________________________

Who does the patient live with: ____________________________

Education: ____________________________

Activity: ____________________________

How Many hours spend on electronics (TV / Phone/ games/ computers) daily? ______________

Current Medications: Names and Dosage including Prescribed, OTC, Vitamins, Herbal Medications:

____

____

____

____

____

Preferred Laboratory Name: ____________________________ Recent Lab done ☐ Yes ☐ No

Preferred Pharmacy Name/ Location: ____________________________

Diet: How many oz. of milk or Formula or Pediasure Daily: ____________________________

How many oz. of Soda/ juice / sports drink daily: ____________________________

Does the patient eat fiber diet? ☐ Yes ☐ Limited ☐ Other ____________________________

Is Patient lactose Intolerant? ☐No ☐Yes ____________________________

Does the patient have a special diet? ☐ No ☐Yes: ____________________________

Does the patient eat fast or slow? ☐ Slow ☐Fast ☐ Average ☐other: ____________________

Birth History if less than 2 years of age: Birth Weight / Height: ____________________

Is the patient premature? ☐No ☐Yes: How many weeks? ____________________

Did the Patient require extra days of Hospitalization at birth? ☐ No ☐Yes: ____________________

Not Mandatory: Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Religion: ____________________________ Race: ____________________________