New Patient Registration Form

WNY Pediatric Gastroenterology
Providing Pediatric Gastroenterology and Nutrition Care

Daniel Gelfond, MD
Humaira Hashmi, MD

List any allergies you child has:_____

Patient Name	**Date of Birth**

Primary Care Physician / Practice	**Office Telephone / Fax**

Pharmacy / Mail order pharmacy /Address	**Telephone / Fax**

Has your child ever seen a Gastroenterologist? ☐Yes or ☐No
If **yes** please provide the following

Name of Gastroenterologist / Location	**Dates when seen**

How did you learn of Dr. Gelfond's and/or Dr.Hashmi's practice in Batavia, NY?

Chief Complaint
Reason your child is being evaluated at the WNY Pediatric Gastroenterology

History of Present Illness (HPI)
How long has the problem been present?
_____

Where is the problem located?
_____

Has your child had any labs or X rays done with in past year? Please list what was done:
_____

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Please list prescription and non-prescription "medicines"/herbal preparations, etc. that your child is receiving:

Medication	Liquid/pill (concentration)	Dosage/amount you give	Times given

Birth History

If your child is less than 6 years please answer the following:

Problems with the pregnancy?_____ How the child was delivered? _____
Medications/herbals, etc. taken by mother?_____
Where was child delivered?_____
Birth weight: _____Birth length _____
Premature ☐Y ☐ N If premature, how early? _____
Problems at birth or immediately after? _____
Age when child passed first stool/meconium: _____
Admitted to special care nursery? ☐Y ☐ N If **Y** reason(s)? _____

Past Medical History

Has your child ever had a surgery? ☐Y ☐ N
Please list surgical procedure(s) _____

Has your child ever stayed in the hospital overnight? _____
Please list last hospitalization and reason(s)_____

Has your child ever experienced trauma (broken bones, auto accident)? ☐Y ☐ N
When?_____Treatment?_____

Does your child had frequent infections ☐Y ☐ N Require frequent antibiotics ☐Y ☐ N
If your child have a chronic disease or condition for which he/she routinely sees a doctor?
Please list known conditions: _____

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Complete Review Of Systems

Has your child had any of the following, check **YES** or **NO**.

Fever	☐Y	☐N	Vomiting	☐Y	☐N
Weight loss	☐Y	☐N	Nausea	☐Y	☐N
Failure to gain weight	☐Y	☐N	Constipation	☐Y	☐N
Eye problems	☐Y	☐N	Diarrhea	☐Y	☐N
Ear problems	☐Y	☐N	Blood in stools	☐Y	☐N
Nose problems	☐Y	☐N	Urinary problems	☐Y	☐N
Mouth problems	☐Y	☐N	Muscle problems	☐Y	☐N
Neck problems	☐Y	☐N	Problems with nerves	☐Y	☐N
Throat problems	☐Y	☐N	High blood pressure	☐Y	☐N
(swallowing, choking)	☐Y	☐N	Seizures, convulsions	☐Y	☐N
Breathing problems	☐Y	☐N	Endocrine problems	☐Y	☐N
Heart problems (murmurs,..)	☐Y	☐N	Problems with blood	☐Y	☐N
Anemia	☐Y	☐N	Joint problems	☐Y	☐N
Sickle Cell Anemia	☐Y	☐N	Rashes	☐Y	☐N
Swelling of hands or feet	☐Y	☐N	Emotional problems	☐Y	☐N
Allergies	☐Y	☐N	Psychiatric problems	☐Y	☐N
Hyperactivity	☐Y	☐N			

If female: Age at first period _____ Date of last period _____

Normal ☐Y ☐N

Frequency of periods _____ Pregnant? ☐Y ☐N

Social History

Please list other children in the family:

Age	Sex	Full or half sibling	Health

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Mother's Health? _____
Mother's Medications?_____
Mother's Occupation?_____
Father's Health?_____
Father's Medication's?_____
Father's Occupation?_____

Please List any other family members (grandparents, cousins, aunts, uncles) with medical problems (Celiac, diabetes, thyroid disease, liver disease, etc):

Family history of gastrointestinal polyps or gastrointestinal cancer ☐Y ☐N
With whom does the child live? Circle all that apply: ☐Mother ☐Father ☐Other siblings ☐Grandmother ☐Grandfather ☐Cousins ☐Others in the household: ____

Where does your child go to school? _____
Grade in school: _____ Child's average grades: _____
Who provides day care?_____Hours per day your child is in day care_____
Sports your child plays_____Other activities _____
Please tell us anything else that you think is important for the treatment of your child

Thank you for taking the time to fill out this form. The information is very important in determining a diagnosis and treatment plan for your child.

This form was completed by (your name)_____

Your relationship to child_____

Physician section only
I have reviewed the information with the family

_____ _____
Physician Signature Date

PLEASE FILL OUR THIS FORM, PRINT AND BRING TO THE OFFICE.

PRINT THIS FORM

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