Blank Children's Hospital
UnityPoint Health

Blank Children's Pediatric Clinic
GI Patient Profile

CHILD'S NAME: _____

DATE OF BIRTH: _____

TODAY'S DATE: _____

Please circle the appropriate answer (N=No, Y=Yes)

INFORMATION PROVIDED BY: _____

RELATIONSHIP TO CHILD:

Parent: ☐ Biological ☐ Foster ☐ Adoptive

Other: _____

A. PREGNANCY AND BIRTH:

Did the mother have an illness during pregnancy?	N	Y
Did the baby have any problems after birth?	N	Y
Was the baby on time?	N	Y
What was the birth weight?		

B. HEALTH HISTORY

Has your child had any surgeries or hospitalizations?	N	Y

Illness	Month/Year	Hospital

C. MEDICATIONS

Please list any medications:

D. ALLERGIES

Does your child have any allergies to medications or foods?	N	Y

If "Yes", please list:

E. SMOKE EXPOSURE

Who Smokes? ☐ None ☐ Mom ☐ Dad
☐ Other: _____

Smoke: ☐ Inside ☐ Outside

F. FAMILY HISTORY

To include the child's parents, siblings, grandparents, aunts, uncles, or first cousins.

Illness	What Family member is affected?
Asthma	
Allergies	
Celiac Disease	
Colon Cancer	
Crohn's Disease	
Cystic Fibrosis	
Diabetes	
Hirschsprung's Disease	
Liver Disease	
Malignant Hyperthermia	
Thyroid Disease	
Ulcer	
Ulcerative Colitis	

Child currently lives with:
☐ Mother ☐ Father ☐ Other: _____
Siblings: _____ # Sisters: _____ # Brothers: _____

List information of parents and siblings:

M=Male F=Female	Name (First/Last)	Healthy Yes/No
Mother		
Father		
Step-Mother		
Step-Father		
Sibling: M / F		
Sibling: M / F		
Sibling: M / F		
Sibling: M / F		
Sibling: M / F		

Any Additional Information: _____