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FOLLOW UP PATIENT INFORMATION QUESTIONNAIRE

Parents/ Guardians: Please help us provide the best possible care for your child by filling out this form.

Patient Name:_______________________________ DOB:_______________________________
Last First Middle

Name of person completing form:_______________ Relationship to patient:_______________

Primary Physician: _______________________ Phone: _______________________
Address: ____

Reason for today's visit?

Are there specific questions or concerns regarding your child which you would like to make certain we discuss during this visit?

____

Are there studies/ evaluations performed since your last visit that you would like to discuss at this visit?
☐No ☐Yes. If so, please provide in advance and/ or bring copy to visit to have copied at check-in.

Current Medications (Please attach a medication sheet if there is not enough space provided)

Medication Name	Dose	Directions
Ex. Methylphenidate ER	10 mg capsule	1 capsule in the AM

Vitamins/ Supplements: ____

____

Drug Allergies/ Adverse Reactions (Please list drug and reaction):_______________________
Food/Seasonal Allergies:____
Does your child have an allergy to Latex? ☐No ☐Yes
Immunizations: ☐ Up to date ☐ Up to date but given on delayed schedule ☐ Not up to date/ deferred
If not up to date, please explain: ____
Hospitalizations or surgeries since last visit? ☐No ☐Yes. If yes, please explain

Changes in birth, developmental, past medical, family or social history (i.e., living circumstances/ custody changes) since last visit? ☐No ☐Yes. If yes, please explain

Please provide any updates on progress in **language, play, social skills, and academic skills** since our last visit:

Educational History:

Name of School: ________________________ School District of Residence:_____________________

Current Grade in School: __________________Average Grades (ie.,As/Bs, 80s/90s):_______________

Type of classroom: ____

Does your children have an ☐ Individualized Education Program (IEP) or ☐ 504 Accommodation Plan? If so, please state the reason for this/ disability categories if known?

EI/ IU/ school supports and therapies

Private therapies

Counseling/ Behavioral therapy services

Extracurricular activities

Additional Comments:

Review of Symptoms: (Please circle any symptoms your child has exhibited over the **past week**)

System	Symptoms			✓ if no current concerns	Other/Details
Constitutional	Weight loss/ gain (circle which)	Fever	Fatigue		
Ophthalmologic	Visual changes	Eye pain	Blurred vision		
Ears, Nose, Mouth, Throat	Sore throat	Ear infection	Hearing difficulties		
Cardiovascular	Heart racing	Heart skipping beats	Chest pain		
Respiratory	Wheezing	Shortness of breath	Cough		
Gastrointestinal	Nausea/ vomiting	Constipation	Diarrhea		
Genitourinary	Bedwetting	Pain urinating	Urinary tract infection		
Musculoskeletal	Muscle pain	Joint pain	Joint swelling		
Integumentary/ Skin	Eczema	Rash	Itchy skin		
Neurological	Headache	Feeling faint	Tics		
Psychiatric	Sadness	Anxiety	Mood swings		
Endocrine	Excessive thirst	Excessive urination	Poor physical growth		
Hematologic/ Lymphatic	Lymph node swelling	Easy bleeding	Easy bruising		
Allergic/ Immunologic	Itchy eyes	Sneezing	Runny nose		

The information above is complete and accurate to the best of my knowledge.

Patient/ Parent/ Guardian Signature Relationship to Patient Date

The information above has been reviewed and formally discussed in depth with the family.

Physician Signature Date

Rev. 10/30/22 br