Pediatric Neurology of Lehigh Valley
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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 M

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

Primary Physician: _____ Phone: _____
Address: _____

Reason for today's visit?

Current Medications (Feel free to 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 you 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: _____

Changes in birth, developmental, past medical, family or social history since last visit? □No □Yes
Explain

Hospitalizations or surgeries since last visit? □No □Yes
Explain

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

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

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

_____

Parent/ Guardian Signature Relationship Date

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

_____

Provider Signature Date

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