

PATIENT HISTORY: FOLLOW UP

PATIENT HISTORY: REVIEW OF SYSTEMS

Please check any problems (boxes) listed below which have significantly affected your child.
(If left "unchecked" the presence of the problem is denied).

Person completing form Patient Mother Father Legal guardian Other _____

Patient's Name _____ Date _____

Constitutional

- Recent weight gain _____ (amount)
- Recent weight loss _____ (amount)
- Fever
- Frequent Infections
Type of Infections:
 - ____ Throat Infections
 - ____ Ear Infections
 - ____ Sinus Infections
 - ____ Pneumonia
 - ____ Blood Infections
 - ____ Skin Infections
 - ____ Bone Infections

Eyes

- Pain
- Redness
- Itching eyes

Ears–Nose–Mouth–Throat

- Nosebleeds
- Loss of smell
- Dryness in nose
- Runny nose
- Oral Thrush
- Hoarseness

Cardiovascular

- High blood pressure
- Heart murmurs
- Shortness of breath

Respiratory

- Cough
- Wheezing

Gastrointestinal

- Vomiting
- Persistent diarrhea

- Reflux

Genitourinary

For Women Only:

- Age when periods began: _____
- Periods regular? Yes No
- How many days apart? _____
- Date of last period? ___ / ___ / ___

Dermatologic (skin)

- Hives
- Eczema
- Rash (other)

- Yeast Infections

Neurological System

- Headaches

Musculoskeletal

- Joint pain
- Joint swelling

Physician Initials _____

Parent Signature _____

What has happened since you were last here?

Name _____ Age _____

Since your last visit, have you?
(If answer is yes, please clarify)

Yes No

- | | | | |
|--|--------------------------|--------------------------|-------------------|
| Changed primary health care providers? | <input type="checkbox"/> | <input type="checkbox"/> | New doctor: _____ |
| Had any illnesses? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Been evaluated by any health care providers? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Had any x-ray, lab or other procedures? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Changes in your family medical history? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Changes in your social history? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Any new drug allergies? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Started, changed or stopped any medications? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

MEDICATIONS

Drug allergies: No Yes To what? _____

Type of reaction: _____

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped?		
			A Lot	Some	Not At All
1.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Natural or Alternative Therapies (chiropractic, magnets, acupuncture, massage, over-the-counter preparations, etc.)

Pharmacy Name: _____ Phone: _____