

* Form must be completely filled out including ALL PRESCRIBED & OVER THE COUNTER medications at EVERY follow up appointment.

Please Give This Form To The Nurse/Medical Assistant In Exam Room

'Specially For Children, Pediatric Gastroenterology

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FOLLOW-UP VIST:

Date: _____

Child's Name: _____ Age: _____

Date of Birth: _____

Referring Physician: _____ Address: _____

Current Primary Care Physician/Pediatrician: _____

1) Has your child been hospitalized or visited a hospital emergency room since the last visit?

No _____ Yes _____ Details: _____

2) List **ALL** medications your child takes daily

MEDICATIONS/ VITAMINS/SUPPLEMENTS	STRENGTH?	HOW MUCH?	HOW OFTEN?

SPECIAL DIET?

3) Has your child had any intolerance or adverse reaction to recommended treatment by this office? No _____ Yes _____ Details:

4) Please list other medical professionals that have seen your child since the last office visit.