Follow up Form

Patient: _____ Date of birth: _____

Are there any concerns you would like to talk to Dr Patel or Dr Smith today? **(YES or NO)**
If yes, please list
_____
_____

Has anything changed since the last time your child was seen? **(YES or NO)**
If yes, please list any changes
_____
_____

Has your child been diagnosed with anything new since child was seen last? **(YES or NO)**
If yes, what is the new diagnosis?
_____
_____

Has there been any ER visits or Hospitalizations? **(YES or NO)**
If yes, when and where
_____
_____

Has there been any Tests, Procedures or Surgeries done? **(YES or NO)**
If yes, what and where
_____
_____

Any New FOOD, DRUG or ENVIROMENTAL allergies **(YES or NO)**
If yes, please List
_____
_____

Please check all that apply:

____ I have prescriptions that need to be refilled
____ I need a school or work excuse
____ I need the attached forms filled out – NOTE: There may be a $25.00 charge for completion of this form. Such forms include: FMLA. Asthma action plans or school notes are **not** included.

Review of Systems

Name:_____ Date of Birth:_____ Date:_____

During the past few weeks, have you had any of the following symptoms? Please bubble all that apply.

CONSTITUTIONAL:

O fever O chills O night sweats
O fatigue O loss of energy O loss of appetite
O unexpected weight loss or gain O no general complaints
O problems with sleeping O snoring
O breathing difficulties O choking/gasping/snorting during sleep
O excessive sleepiness during the day O morning headaches
O dry mouth/sore throat upon wakening O difficulty falling asleep
O frequent awakening during the night O excessive movements during sleep
O other sleep difficulties O no sleeping problems

EYES:

O dry eyes O eye pain
O watery eyes O itchy eyes
O vision changes

EARS, NOSE AND MOUTH:

O nasal congestion O sinus pressure O facial pain
O nasal discharge O nose bleeds O nasal ulcers O ear pain
O ear discharge O dry mouth O oral ulcers O tooth pain
O bad breath O postnasal drip O sore throat O enlarged tonsils
O recurrent strep throat O sensation of fluid or fullness in the ear O no complaints

HEART:

O chest pain O palpitations O racing heart rate
O shortness of breath O swelling in the legs O no complaints

LUNGS:

O shortness of breath at rest O shortness of breath with normal daily activities
O shortness of breath with exercise O wheezing
O cough with sputum production O cough without sputum production
O blood tinged phlegm or coughing up blood O no lung complaints

STOMACH AND INTESTINES:

O nausea O vomiting O diarrhea O constipation
O abdominal pain O heartburn O jaundice O abdominal fullness
O no complaints

GENITO-URINARY SYSTEM:

O painful urination O blood in urine O urgent or frequent urination O no complaints

PSYCHIATRIC:

O depression O anxiety O panic attacks O no complaints

MUSCLES AND JOINTS:

O joint pain O joint swelling O joint stiffness
O muscle aches O muscle weakness O no complaints

NEUROLOGICAL SYSTEM:

O headache O seizures O tremors
O vision changes O weakness O sensory changes
O difficulty with memory O no neurological problems/complaints

SKIN:

O eczema (dry/itchy skin) O rash O hives
sun sensitivity O psoriasis O no skin complaints

HEMATOLOGICAL/LYMPHATIC SYSTEM:

O easy bruising O easy bleeding O history of blood clots (DVT) O blood clot antibody
O no complaints O swollen lymph nodes O no swollen lymph nodes

ENDOCRINE AND METABOLISM:

O heat intolerance O cold intolerance O frequent need to urinate
O always thirsty O intermittent vision changes
O problems with your thyroid O no metabolic or endocrine problems

ALLERGY/IMMUNOLOGY:

O anaphylaxis O angioedema
O no complaints O frequent infections