Rocky Mountain Pediatric Neurology & Sleep Medicine

Follow-Up History Form

For Office Use Only: Primary Ins.: _____ Secondary Ins:_____

General Information

Patient Name:	Date of birth:

Chief complaint (Reason for visit)

Review of Systems (Make an 'X' next to all RECENT symptoms) [ ] NO TO ALL

Constitutional:-→	*Fever?*		*Weight change?*		*Sleep disturbance?*		
Allergic/Immunologic:	*Frequent infections?*		*Food allergies?*				
Skin:→	*Rash?*		*Birth marks?*		*Moles?*		
Eyes:→	*Blurry vision?*		*Double vision?*		*Pain?*		
Ears, nose, throat:→	*Hearing loss?*		*Congestion?*		*Sore throat?*		
Respiratory:→	*Shortness of breath?*		*Cough?*		*Wheezing?*		
Cardiovascular:→	*Chest pain?*		*Palpitations?*		*Fainting?*		
Gastrointestinal:→	*Vomiting?*		*Diarrhea?*		*Abdominal pain?*		
Genitourinary:→	*Incontinence?*		*Pain?*		*Change in frequency?*		
Musculoskeletal:→	*Joint pain?*		*Pain or cramps?*		*Weakness?*		
Neurologic:→	*Headaches?*		*Numbness?*		*Tremors?*		
Psychiatric:→	*Depression?*		*Anxiety?*		*ADHD?*		
Hematologic:-→	*Abnormal bleeding?*		*Easy bruising?*		*Anemia?*		
Endocrine:→	*Excessive sweating?*		*Loss of energy?*		*Cold intolerance?*		

Have you been feeling "down", "depressed" or "hopeless" within the last two weeks? ☐☐ Y/N
Do you do any activities (i.e. sports, crafts, clubs, horseback riding, etc.) that you enjoy?

_____

Medications (Please list ALL Current Medications)

Medication	*Dose and frequency*
Medication	*Dose and frequency*
Medication	*Dose and frequency*
Medication	*Dose and frequency*

Immunizations up to date? ☐ ☐ Y / N **Have you receive the Flu Vaccine? ☐☐ Y/N** **If Yes, When? _____**

Interval Medical History (PLEASE LIST ANY CHANGES SINCE LAST VISIT) [] No changes

Please list any new diagnoses, hospitalizations or surgeries:

Rocky Mountain Pediatric Neurology & Sleep Medicine

Follow-Up History Form

For Office Use Only: Primary Ins.: _____ Secondary Ins:_____

Drug Allergies [] None

Drug	*Reaction*

Family History (PLEASE LIST ANY CHANGES SINCE LAST VISIT) [] No changes

New diagnoses, include which family member

Are there any family members who have or had any of the following conditions (please circle all that apply)? [] NO

Seizures/epilepsy, developmental delay, mental retardation, learning disability, cerebral palsy, multiple sclerosis, stroke, muscular dystrophy, headache/migraine, tremor, tics, ADHD, autism, depression, schizophrenia, other neurologic disease or psychiatric disease

Social History (PLEASE LIST ANY CHANGES SINCE LAST VISIT) [] No changes

Household members, current grade in school, school performance, alcohol/drug/tobacco use

Development (PLEASE LIST ANY CHANGES SINCE LAST VISIT) [] No changes

Please list any new skills obtained since last visit, include age obtained

Any developmental regression (loss of previously acquired skills)? ☐Y/N☐

Please share any additional information you think may be helpful

Do you have any specific questions or concerns today?

Signature	*Relationship*	*Date*