



Follow-Up History Form

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

General Information

Patient Name:	Date of birth:
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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)

<i>Medication</i>	<i>Dose and frequency</i>
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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:



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Drug Allergies None

<i>Drug</i>	<i>Reaction</i>

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?

<i>Signature</i>	<i>Relationship</i>	<i>Date</i>
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