Rocky Mountain Pediatric Neurology & Sleep Medicine
Follow-up History Form

General Information

Patient Name:	Date of birth:

Chief complaint (why you are here)

Interval Medical History (since last visit) [] None

Please list any new diagnoses, hospitalizations or surgeries:

Drug Allergies [] None

Drug	*Reaction*

Immunizations up to date? y/n

Medications

Please list all current medications	
Medication	*Dose and frequency*
Medication	*Dose and frequency*
Medication	*Dose and frequency*
Medication	*Dose and frequency*

Social History (please list any changes since last visit) [] No changes

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

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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*

Development

Please list any new skills obtained since last visit, include age obtained
Any developmental regression (loss of previously acquired skills)? y/n

Review of Systems (please answer y/n to all recent symptoms)

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

Please share any additional information you think may be helpful

Do you have any specific questions or concerns today?

Signature	*Relationship*	*Date*