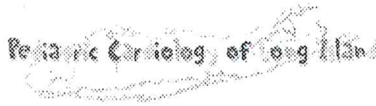

FOLLOW-UP VISIT PATIENT INTAKE FORM

Date of Visit: ____________________

Name: ____ **Date of Birth:** ____________________

REASON FOR COMING TO THE DOCTOR TODAY:

Reason for Today's Visit: ____

____

____

MEDICATION HISTORY:

List any prescription or over the counter medications, vitamins, minerals, and herbals that you (the patient) are currently taking:

☐**Not currently taking any medications**

Name of Medication	Dosage	Name of Medication	Dosage

Medical/Surgical History:

Since the last visit here has the patient:	Yes	No
Been diagnosed with a new medical problem	☐	☐
Had a change in an existing medical problem (new medicine, procedure, etc.)	☐	☐
Been admitted to the hospital or surgery/any other procedure	☐	☐
Had an unexpected visit to the doctor or emergency room	☐	☐
Started seeing a new primary doctor, specialist, therapist	☐	☐

If you answered "Yes" above, please explain: ____

____

____

Family History:

Since the last visit here, has anyone in the patient's family Developed a heart problem or a new significant medical problem?

If yes, please explain:

____

SOCIAL HISTORY:

Please describe the patient's Family Members? ☐Mother ☐Father ☐Brother(s)____ ☐Sister(s)____

Other (list): ____

Please describe your (the patient's) *current* School Status? ☐Regular school ☐Special education ☐Full-time ☐Part-time

Tobacco/Smoke 2nd hand Exposure Details: ☐None ☐Minimal ☐Frequent ☐Daily

☐Current every day smoker ☐Current some day smoker ☐Former Smoker ☐Never Smoked ☐Unknown

Have you (the patient) ever used any illicit drugs? ☐Yes ☐No

If yes, please indicate what type of drug and how often: ____________________

Do you (the patient) drink alcoholic beverages? ☐Yes ☐No

If yes, please indicate what type of beverage and how many servings per day: ____________________

Do you (the patient) drink caffeinated beverages? ☐Yes ☐No

If yes, please indicate what type of beverage and how many servings per day: ____________________

Please describe your (the patient's) current exercise routine: ☐Inactive ☐Light ☐Moderate ☐Heavy

FOLLOW-UP VISIT PATIENT INTAKE FORM (Page 2 of 2)

REVIEW OF SYSTEMS:

Has the patient recently experienced any of the following symptoms? *Please mark either Yes or No for each of the items below.* If you don't understand something place a question mark "?" by it. Your doctor will discuss any positive responses with you.

General:	Yes	No
• Easy Fatigue	☐	☐
• Frequent Infections	☐	☐
• Paleness	☐	☐
• Poor Weight Gain	☐	☐
• Recent Weight Loss/Gain	☐	☐

Skin:	Yes	No
• Abnormal Color: Blue or Very Pale	☐	☐
• Eczema	☐	☐
• Hemangiomas/Birthmarks	☐	☐
• Prominent Veins	☐	☐
• Rash	☐	☐

Cardiovascular:	Yes	No
• Blueness	☐	☐
• Chest Pain	☐	☐
• Dizziness	☐	☐
• Easy Fatigue	☐	☐
• Heart Murmur	☐	☐
• High Blood Pressure	☐	☐
• High Cholesterol	☐	☐
• Irregular Heart Beat	☐	☐
• Low Blood Pressure	☐	☐
• Palpitations or Rapid Heart Beat	☐	☐
• Passing Out	☐	☐
• Poor Exercise Tolerance	☐	☐

Gastrointestinal:	Yes	No
• Coughing/ Choking when Eating	☐	☐
• Difficulty Feeding	☐	☐
• Frequent Diarrhea	☐	☐
• Frequent Vomiting	☐	☐
• Heartburn/Stomach Aches	☐	☐
• Poor Eater	☐	☐

HEENT:	Yes	No
• Blurry Vision	☐	☐
• Cracked/Sore/Red Lips	☐	☐
• Ear Pain	☐	☐
• Glasses/Contact Lenses	☐	☐
• Hearing Loss	☐	☐
• Loss or Change of Vision	☐	☐
• Nasal Congestion	☐	☐
• Nosebleed	☐	☐
• Pink/Red Eyes	☐	☐
• Seasonal/Chronic Runny Nose	☐	☐
• Sore Throat	☐	☐
• Watery Eyes	☐	☐

Genitourinary:	Yes	No
• Blood in Urine	☐	☐
• Decreased Urine	☐	☐
• History of Urinary Tract Infections	☐	☐
• Painful Urination	☐	☐

Musculoskeletal:	Yes	No
• Chest Cavity Abnormality	☐	☐
• Joint or Muscle Pain	☐	☐
• Joint or Muscle Swelling	☐	☐
• Loose/Flexible Joints	☐	☐
• Redness/ Inflammation of Joints	☐	☐
• Scoliosis	☐	☐

Hematology:	Yes	No
• Anemia	☐	☐
• Easy Bruising/Bleeding	☐	☐
• Swollen/Enlarged Lymph Nodes	☐	☐

Neck:	Yes	No
• Neck Pain	☐	☐
• Neck Stiffness	☐	☐
• Neck Swelling	☐	☐

Respiratory:	Yes	No
• Asthma	☐	☐
• Chest Pain	☐	☐
• Difficulty Breathing	☐	☐
• Frequent Coughing	☐	☐
• Lung Collapse	☐	☐
• Noisy Breathing	☐	☐
• Pneumonia	☐	☐
• Shortness of Breath	☐	☐
• Wheezing	☐	☐

Psychiatric:	Yes	No
• Depression	☐	☐
• Mood Swings	☐	☐
• Nervousness	☐	☐
• Temper Outburst	☐	☐

Endocrine/Glands:	Yes	No
• Excessive Sweating	☐	☐
• Excessive Thirst/Hunger	☐	☐
• Heat or Cold Intolerance	☐	☐

Neurological:	Yes	No
• Abnormal Movements	☐	☐
• Diagnosis of AHD/ADD	☐	☐
• Difficulty Speaking	☐	☐
• Headaches	☐	☐
• Numbness	☐	☐
• Seizures	☐	☐
• Weakness	☐	☐

Form Filled Out By:

☐Patient, ☐Mother, ☐Father, ☐Relative: ________________, ☐Staff: ________________, ☐Translator: ________________

Physician Review: ______________________________ **Date:** ________________

☐AMV ☐SGL ☐DML ☐JIH