Patient Name___________________________ Date of Birth___/___/___ Today's Date ___/___/___

Follow-up Questionnaire

Please indicate answers by filling in the blank or checking YES or NO

Past Family, Social, and Medical History

Please answer the questions with regard to changes since the patient's last visit to the clinic.

Question		
Does the patient have the same regular doctor?	YES	NO
*If NO, please list the new doctor:		
If the patient uses home medical equipment (oxygen, feeding pump, apnea monitor, etc), has any equipment been added or discontinued?	YES	NO
*If YES, what?		
If the patient uses home medical equipment, has the home care company changed?	YES	NO
*If YES, what is the name of the new company?		
Does the patient have any new allergies to any medications, foods, insects, or animals?	YES	NO
*If YES, what?		
Have there been any changes to the patient's family medical history?	YES	NO
*If YES, what?		
Have there been any changes to child care arrangements for the patient?	YES	NO
*If YES, what?		
Are there any new cultural concerns we need to be aware of?	YES	NO
*If YES, what?		
Have there been any changes to the patient's household (births, etc.)?	YES	NO
*If YES, what?		
Have there been any changes to the patient's housing situation?	YES	NO
*If YES, what?		
Does the patient have any new household pets?	YES	NO
*If YES, what?		
Any changes to the condition of the patient's home?	YES	NO
*If YES, what?		
Does anyone currently smoke?	YES	NO

Patient Name__________________________ Date of Birth____/____/____ Today's Date ____/____/____

Do you live with or close to other domesticated / non-domesticated animals such as: birds, farm animals, etc?	YES	NO
*If YES, what?		
What grade is the patient in currently?		
Has the patient started any new hobbies, activities or sports?	YES	NO
*If YES, what?		
Has the patient had any urgent or emergent visits to a physician or ER, or hospital or PICU admission since the last clinic visit?	YES	NO
*If YES, please describe:		
Has the patient had surgery since the last visit?	YES	NO
*If YES, please describe:		

Since the last clinic visit, has the patient had any of the following symptoms? (check YES or NO)

Constitutional	YES	NO
Fever (recent, or recurrent)		
Chills		
Night sweats		
Weight loss or gain (circle which)		
Decreased energy		
Appetite changes		
Difficulty gaining weight?		
Eye	YES	NO
Vision problems (glasses or contacts)		
Itchy eyes		
Watery eyes		
Red eyes		

Ear, Nose, Mouth, & Throat	YES	NO
Hearing problems		
Ringing in ears		
Frequent ear infections?		
Runny nose		
Nasal congestion		
Frequent sinus infections		
Frequent sniffing or sneezing		
Nose bleeds		
Mouth sores or ulcers		
Problems with teeth (cavities, braces, etc)		
Hoarse voice		
Frequent throat clearing		
Frequent colds or sore throat?		
Cardiovascular	YES	NO
Heart murmur or heart problem		
Chest pain		
Exercise limitation		
High blood pressure		
Fainting spells		
Gastrointestinal	YES	NO
Diarrhea		
Constipation		
Vomiting or excessive spit up		
Nausea		
Heart burn		
Frequent stomach ache or abdominal pain		
Burping		
Hiccups		
Oil or grease in bowel movements		
Problems with feeding, swallowing, or drinking liquids		
Intolerance to certain foods		
History of iron or other nutritional deficiency		
Genitourinary	YES	NO
Waking up at night to urinate		
Bed-wetting		
Other problems with kidneys, bladder or urination?		

Patient Name__________________________ Date of Birth____/____/____ Today's Date ____/____/____

Musculoskeletal	YES	NO
Scoliosis (curved spine)		
Back pain		
Joint pain or swelling		
Integumentary	YES	NO
Rash		
Other skin problems or conditions		
Neurological	YES	NO
Headaches		
Convulsions or seizures		
Other problems with the nervous system		
Learning disability / differences		
Problems focusing or paying attention		
Hyperactive		
Developmental delays?		
New problems with speech, language, or hearing?		
Does your child receive special therapy for any of the above conditions?		
Is your child enrolled in ECI?		
Does your child require special classes in school?		
Does your child require therapy? (speech, physical, occupational) please circle		
Sleep	YES	NO
Problems falling asleep?		
Problems with sleep?		
Snore?		
Have you ever seen your child stop breathing while asleep?		
Sleepiness during the day (falling asleep in class)?		
How many hours does the patient sleep on school nights (weeknights)?		
How many hours does the patient sleep on weekend nights?		
How many naps does the patient take per day?		
Psychiatric	YES	NO
Anxiety		
Depression		
Behavioral problems (fighting at school, etc)		
Other psychiatric conditions		

Endocrine	YES	NO
Adrenal or thyroid problems		
Blood sugar problems (including diabetes)		
Take birth control pills?		
Other endocrine or hormonal problems		
Hematologic / Lymphatic	YES	NO
Easy bruising		
Pale appearance		
Has the patient ever been anemic?		
Allergic / Immunologic	YES	NO
Eczema (atopic dermatitis)		
Hives (urticaria)		
Allergies (allergic rhinitis, hay fever, etc)		
Milk allergy		
Egg allergy		
Peanut allergy		

*Please note any other important facts or symptoms not listed above:

Completed by ____________________________________
(signed)

____
(print name)

Completed on _______/_______/200___

Relationship to patient ____________________________

Reviewed By :________________________________