



Today's Date: _____

Follow Up Patient Information Sheet

Thank you for choosing us as your care provider.

New address/phone number: N/A

CURRENT MEDICATIONS

1. _____
2. _____
3. _____
4. _____

Changes in your medical history since last visit

New diagnoses: _____

Hospitalizations: _____

Surgeries: _____

CURRENT/NEW CONCERNS:

Email address _____

Would you like to be on our email newsletter list?
 Yes No (All email address will remain confidential and emails will be sent by Bcc)

REVIEW OF SYSTEMS: Has your child had?

- Weight loss, weight gain Yes No
- Headaches Yes No
- Drinking a lot Yes No
- Eating a lot Yes No
- Vision, Hearing problems Yes No
- Frequent infections Yes No
- Feeling very hot or cold Yes No
- Cough Yes No
- Heart flutters Yes No
- Any Pain Yes No
- Vomiting Yes No
- Diarrhea Yes No
- Constipation Yes No
- Rashes Yes No
- Dry skin Yes No
- Stretch Marks Yes No
- Abnormal hair growth Yes No
- Abnormal body odor Yes No
- Development of puberty Yes No
- Numbness of hands/feet Yes No
- Trouble sleeping Yes No
- Behavioral changes Yes No
- Hair Loss Yes No

INSULIN (for diabetic patients only)

Time	Insulin	Carb Ratio
Breakfast		
Lunch		
Dinner		
Bedtime		
Blood Sugar correction:		