Patient Label

Today's Date:__________________________

Follow Up Patient Information Sheet
Thank you for chosing 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:		