Pediatric Return Patient History Form

1. What is new or different about your child since he/she was last seen here?  
   NO [  ]  YES [  ]  
   Explain: ____________________________________________
   ____________________________________________

2. Has there been any change to your home or social situation since your child was last seen here?  
   (i.e. new school, change in living situation, etc)  
   NO [  ]  YES [  ]  
   Explain: ____________________________________________
   ____________________________________________

3. Has your child had any new illnesses, medical conditions, or surgical procedures since you were last seen in this clinic?  
   NO [  ]  YES [  ]  
   Explain: ____________________________________________
   ____________________________________________

4. Has your child been to the Emergency Room or admitted to the hospital since she/he was last seen in this clinic?  
   NO [  ]  YES [  ]  
   Explain: ____________________________________________
   ____________________________________________

5. Has anyone in your family been diagnosed with any new medical condition since your child was last seen in this clinic?  
   NO [  ]  YES [  ]  
   Explain: ____________________________________________
   ____________________________________________

6. Has your child developed any new drug allergies since he/she was last seen here?  
   NO [  ]  YES [  ]  
   Explain: ____________________________________________
   ____________________________________________
# REVIEW OF SYMPTOMS

Please mark the box and/or circle any persistent symptoms you have had in the past few months. Read through every section and check "no problems: if none of the symptoms apply to you. List other concerns above.

## General
- Fever/chills
- Night sweats
- Unexplained weakness
- Excessive fatigue
- Decreased activity
- Unexplained weight loss/gain
- **No Problems**

## Respiratory
- Shortness of Breath
- Cough
- Wheezing
- Loud Snoring
- Short of breath – exercise
- **No Problems**

## Genitourinary
- Urinating More Often
- Wetting the bed at night
- **No Problems**

## Neurological
- Headache
- Memory loss/confusion
- Fainting
- Dizziness
- Numbness/Tingling
- Unsteady Gait
- Frequent Falls
- Tremors
- Seizures
- **No Problems**

## Eye
- Eye Mattering/Discharge
- Blurred/Double Vision
- Glasses/Contact Lenses
- **No Problems**

## Cardiovascular
- Chest Pain/Discomfort
- Heart Palpitations
- Swelling in legs/feet
- **No Problems**

## Musculoskeletal
- Back Pain
- Neck Pain
- Muscle Aches/Cramps
- Joint Pain
- Muscle Weakness
- Decreased Joint Motion
- Joint Stiffness
- **No Problems**

## Gastrointestinal
- Nausea/Vomiting
- Diarrhea
- Blood in Stools
- Constipation
- Abdominal Pain
- Heartburn/Reflux
- Indigestion
- Irritable Bowel Syndrome
- **No Problems**

## Skin
- Rash
- Itching
- New Change in mole
- Hair Loss/Change
- Change in nails
- **No Problems**

## Ear/Nose/Throat
- Sore Throat/Hoarseness
- Trouble Swallowing
- Hearing loss
- Ear pain
- **No Problems**

## Hematologic/Lymphatic
- Bruise Easily
- Bleeding Tendency
- Swollen glands
- **No Problems**

## Psychiatric
- Anxiety/Stress/Irritability
- Sleep Problems
- Lack of Concentration
- Change in Behavior
- Change in Personality
- Anorexia
- Binging/Purging
- **No Problems**

## Endocrine
- Heat Sensitivity
- Cold Sensitivity
- Excessive Thirst
- Excessive Hunger
- High/Low blood sugar
- **No Problems**