University Physicians
*University of Missouri Health Care*

Woodrail General Internal Medicine/Pediatrics

Name_____ Date_____
Date of Birth_____ Place of Birth_____
Parent/Guardian 1: _____
Parent/Guardian 2: _____
E-mail Address_____
Preferred Method of Communication_____

# 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***

**Eye:**
__Eye Mattering/Discharge
__Blindness
__Blurred/Double Vision
__Glasses/Contact Lenses
__***No Problems***

**Ear/Nose/Throat:**
__Nose Bleeds
__Nasal Congestion
__Sore Throat/Hoarseness
__Trouble Swallowing
__Hearing loss
__Ear pain
__Dental cavities
__***No Problems***

**Respiratory:**
__Shortness of Breath
__Cough
__Wheezing
__Loud Snoring
__Short of breath – exercise
__***No Problems***

**Cardiovascular:**
__Chest Pain/Discomfort
__Heart Palpitations
__Swelling in legs/feet
__***No Problems***

**Gastrointestinal:**
__Nausea/Vomiting
__Diarrhea
__Blood in Stools
__Constipation
__Abdominal Pain
__Heartburn/Reflux
__Indigestion
__Bloating
__Loss of bowel control
__Problems eating
__Loss of appetite
__Excessive gas
__Rectal Pain
__***No Problems***

**Genitourinary:**
__Urinating More Often
__ Wetting the bed at night
__***No Problems***

**Musculoskeletal:**
__Back Pain
__Neck Pain
__Muscle Aches/Cramps
__Joint Pain
__Muscle Weakness
__Decreased Joint Motion
__Joint Stiffness
__***No Problems***

**Hematologic/Lymphatic:**
__Bruise Easily
__Bleeding Tendency
__Swollen glands
__***No Problems***

**Skin:**
__Rash
__Itching
__New Change in mole
__Hair Loss/Change
__Change in nails
__***No Problems***

**Neurological:**
__Headache
__Memory loss/confusion
__Fainting
__Dizziness
__Numbness/Tingling
__Unsteady Gait
__Frequent Falls
__Tremors
__Seizures
__***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***