



For office use only:

W: _____ H: _____ T: _____

Established Patient History

Please answer all of the questions below regarding the patient's medical history since your last office visit

Patient Information:

Name: _____

Date of Birth: _____

Medical History:

Since your last office visit, has the patient been diagnosed with any new medical conditions, been hospitalized, or undergone surgery?

No Yes (If yes, please describe)

Medications:

Since your last office visit, has the patient started or discontinued any prescription medications, over-the-counter medications, vitamins, or supplements?

No Yes (If yes, please list medication and dosage)

Allergies:

Since your last visit, has the patient developed any new allergies to medications or other materials?

No Yes (If yes, please describe)

Social History:

Since your last visit, has the patient changed grades in school, changed school locations, or started/stopped any sports or other recreational activities?

No Yes (If yes, please describe)

Review of systems:

In the last 3 months, has the patient experienced any new symptoms that were not present at your last office visit:

- | | |
|--|--|
| Fever: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Weight gain or loss greater than 5 pounds: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Difficulty seeing: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Difficulty hearing: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Chest pain: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Wheezing: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Constipation: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Pain with urination: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Rashes: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Anxiety: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Other: | <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please describe) |

To the best of my knowledge, my answers are correct: _____
Signature (Parent/Guardian) Date

Signature (Provider) Date

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