



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

Dallas Location
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