INOVA Children's

Follow Up Patient Questionnaire

Clinician: ____

Today's date ______ / ______ / ______	
PATIENT NAME:	**DOB** ____ / _____ / _______
Accompanying adult: **Relationship to patient:**	
What are your concerns that you would like to discuss with your doctor today?	
Since your last visit, have you:	**If yes, please provide details**
Experienced any new illnesses, surgery or hospitalizations ☐ **No** ☐ **Yes**	
Had blood work, x rays, ultrasound, CAT scan or MRI? ☐ **No** ☐ **Yes**	
Changed any medications including non-prescription? ☐ **No** ☐ **Yes**	
Learned of relatives that have developed a new chronic illness? ☐ **No** ☐ **Yes**	
Experienced any major change at home, school, work, or in personal situation or health (e.g. diet, exercise, tobacco use, alcohol use)? ☐ **No** ☐ **Yes**	
Since your last visit have you experienced any change in symptoms:	**If yes, please provide details**
Fever, fatigue, feeling too warm or too cold most of the time ☐ **No** ☐ **Yes**	
Weight loss, weight gain, increased thirst ☐ **No** ☐ **Yes**	
Eyes / Vision (blurred or double vision, tearing, swelling) ☐ **No** ☐ **Yes**	
Ears, nose, mouth, throat (Swelling, tender, difficulty swallowing, unable to smell, snoring, frequent ear infections, hearing problems) ☐ **No** ☐ **Yes**	
Heart (chest pain, palpitations) ☐ **No** ☐ **Yes**	
Lungs (shortness of breath, cough) ☐ **No** ☐ **Yes**	
Digestion (constipation, diarrhea, belly pain, vomiting) ☐ **No** ☐ **Yes**	
Urinary (pain with urination, frequent urination, bedwetting) ☐ **No** ☐ **Yes**	
Muscles, joints (aches, cramps, pain on walking) ☐ **No** ☐ **Yes**	
Skin, nails and hair (dryness, brittle nails, hair loss) ☐ **No** ☐ **Yes**	
Neurological (Headaches, numbness, weakness, dizziness) ☐ **No** ☐ **Yes**	
Emotional (Depression, sleep disorder, difficulty concentrating, anxiety) ☐ **No** ☐ **Yes**	
Reproductive (change in menstruation, body odor, early pubic/axillary hair, age of first period ever and date of last period- if applicable) ☐ **No** ☐ **Yes**	

Thank you for filling out this questionnaire, which helps us serve you better !

Patient Identification

If label is not available, please complete:

Patient Name ________________________________

DOB: ______________ MR# ___________________

Office Use Only

I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

___It was emergency treatment

___I could not communicate with the patient

___The patient refused to sign

___The patient was unable to sign because

___Other (please describe)

Signature ______________________________________