PHOENIX CHILDREN'S Medical Group

Division of Genetics

FOLLOW-UP PATIENT QUESTIONNAIRE

Apply Patient Label

Mailing Address_____

Phone number (home) _____ (cell number) _____

Email address: _____

If there are any changes to your/your child's care providers (PCP or specialists) please list them here:

_____

_____

Are there sensitive issues you do not want to discuss today in front of your child? Please explain:

_____

_____

Do you have any specific questions or concerns you would like to discuss at today's visit?

_____

_____

Please describe your/your child's current diet (type of food/formula, amount, frequency, aversions):

_____

_____

Please list any medications you/your child are currently taking:

_____ _____ _____ _____

_____ _____ _____ _____

Please list any surgeries since your last visit (include approximate date):

1) _____ 3) _____

2) _____ 4) _____

Please list any overnight hospitalizations since your last visit (include approximate date):

1) _____ 3) _____

2) _____ 4) _____

Please list any imaging studies done since your last visit (MRI, CT, Ultrasound, X-Rays, Echocardiogram, etc.). Include who ordered the test and result (if you know it):

_____

_____

Please list any genetic testing or other significant lab work NOT ordered by us since your last visit:

_____

_____

Please check any medical problems that have come up since your last visit:

Systemic:
- ❑ Fever
- ❑ Weight Loss
- ❑ Weight Gain
- ❑ Fatigue
- ❑ Other _____

Ears/Nose/Throat:
- ❑ Frequent ear infections
- ❑ Hearing loss
- ❑ Congestion
- ❑ Snoring
- ❑ Other _____

Gastrointestinal:
- ❑ Poor Appetite
- ❑ Picky Eater
- ❑ Eats Too Much
- ❑ Esophageal Reflux

FREQUENT:
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Abdominal Pain
- ❑ Other _____

Psychiatric:
- ❑ Behavioral Concerns
- ❑ Tantrums
- ❑ Depression
- ❑ Anxiety
- ❑ Hyperactive
- ❑ Psychotic
- ❑ Other _____

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Eyes:
- ❑ Wears glasses
- ❑ Astigmatism
- ❑ Lazy Eye/Strabismus
- ❑ Clogged Tear Ducts
- ❑ Other _____

Skin:
- ❑ Rashes
- ❑ Birthmarks
- ❑ Eczema
- ❑ Jaundice
- ❑ Problems with Wound Healing
- ❑ Other _____

Heart:
- ❑ Murmur
- ❑ Fainting
- ❑ Chest Pain
- ❑ Turning Blue
- ❑ Other _____

Lung:
- ❑ Cough
- ❑ Asthma
- ❑ Shortness of Breath
- ❑ Other _____

Genitourinary:
- ❑ Bed-wetting
- ❑ Urinary Tract Infections
- ❑ Blood in Urine
- ❑ Undescended Testicle(s)
- ❑ Other _____

Neurologic:
- ❑ Headaches
- ❑ Migraines
- ❑ Seizures
- ❑ Sleep Problems
- ❑ Balance Problems
- ❑ Weakness
- ❑ Low Muscle Tone
- ❑ High Muscle Tone
- ❑ Other _____

Musculoskeletal:
- ❑ Bone Fracture(s)
- ❑ Too Flexible
- ❑ Too Stiff
- ❑ Muscle Pain
- ❑ Joint Pain
- ❑ Joint Swelling
- ❑ Scoliosis
- ❑ Joint Dislocations
- ❑ Other _____

Heme/Lymph:
- ❑ Nosebleeds
- ❑ Easy Bruiser
- ❑ Bleeds Too Long
- ❑ Swollen Glands/Nodes
- ❑ Other _____

Endocrine:
- ❑ Temperature Regulation Problem
- ❑ Low Blood Sugar
- ❑ High Blood Sugar
- ❑ Hormone Problem
- ❑ Drinking/Urinating Too Much
- ❑ Other _____

Allergy/Immunology:
- ❑ Frequent Infections
- ❑ Food Allergies
- ❑ Environmental Allergies
- ❑ Other _____

Current Therapies:
- ❑ Physical Therapy
- ❑ Occupational Therapy
- ❑ Speech Therapy
- ❑ Feeding Therapy
- ❑ Vision Therapy
- ❑ Music Therapy
- ❑ ABA Therapy
- ❑ Developmental Therapy
- ❑ Other _____

Current Education:
- ❑ Grade: _____
- ❑ Special Education
- ❑ IEP
- ❑ 1:1 Aide
- ❑ 504 plan
- ❑ Regular classes
- ❑ Homeschool

_____ _____
Signature of Patient/ Legally Authorized Representative Date

_____ _____
Printed Name of Patient/ Legally Authorized Representative Relationship to Patient

_____ _____ _____
Practitioner Signature Date Time

_____
Printed Name