AdventHealth
Medical Group

ESTABLISHED PATIENT FORM

FOLLOW-UP ROOM #: ______________

PATIENT NAME: ________________________________ DATE OF BIRTH: ____________ AGE: _________ DATE: __________

Referring Physician: __________________________________ Primary Care Physician: ________________________________

HISTORY - COMPLETED BY PATIENT / PARENT

1. Reason for your visit today ____

2. Please indicate if you (the patient) are having any current problems, signs or symptoms in any of the following areas:

	No	Yes		No	Yes
Fever, weight loss, fatigue, etc.	❑	❑	Neurological	❑	❑
Eyes	❑	❑	Allergies	❑	❑
Skin	❑	❑	Urinary / Reproductive	❑	❑
Ears, Nose, Throat	❑	❑	Thyroid / Endocrine	❑	❑
Stomach / Digestion	❑	❑	Psychiatric	❑	❑
Lungs / Breathing	❑	❑	Blood / Lymph	❑	❑
Heart / Circulation	❑	❑	Other	❑	❑
Muscle / Joints / Bones	❑	❑	Other	❑	❑

____

Last Dental Visit: ____

Is the patient menstruating? ❑ NO ❑ YES Last menstrual period: ______________________________

3. Present medications: ____

____

____

4. Are the patient's immunizations up to date? ❑ YES ❑ NO

5. **HAS THE PATIENT HAD ALLERGIC REACTIONS?** ❑ NO ❑ YES

If yes, please describe: ____

____

6. Are there any concerns about any changes in the patient's condition? ❑ NO ❑ YES

If yes, please describe: ____

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7. Since your last visit, please note any changes to: Surgeries Performed, Cardiac Cath's Performed, Cardiac Ablation

Health of a Family Member: ____

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____

8. Who does the patient live with? (Mom, Dad, Sister, Brother, Spouse. etc.) ______________________________

Any forms to be completed? (FMLA, Physical, School note, etc.) _______________________________________

Patient / Legal Guardian Signature ____________________________________ Date ______________________

Physician Signature ____ Date ______________________