

# Follow-up Parent Questionnaire (Young & Older Teen)

<b>Full Name of Patient:</b>			
Date of birth:		Today's Date	
Name of person Completing the Form:			
<b>Today's Appointment</b>			
What is the main reason for your appointment today?		<input type="radio"/> Specific Question/Concern	<input type="radio"/> General Checkup
What is the most important concern you wish to discuss with the doctor today?			

<b>ALLERGIES to medications, with type of reaction (e.g. Penicillin, Hives)</b>			
<b>Immunization History (Please bring copy of immunization record)</b>			
Immunization History	<input type="radio"/> Up to date	<input type="radio"/> Incomplete	<input type="radio"/> Not Sure
Has he/she had chicken pox disease?	<input type="radio"/> Yes	<input type="radio"/> No	

Current Medications, Vitamins, Supplements	Dose	How Often	Prescribing Physician

In the past year have there been any new changes in health?			
Surgeries	Injuries	Illnesses	Hospitalizations

In the past year have there been any changes at home?		
<input type="radio"/> Move	<input type="radio"/> Death / illness	<input type="radio"/> Changing school
<input type="radio"/> Separation / Divorce	<input type="radio"/> Other _____	

Please help us get to know your child	
What about him/her makes you proud?	
What seems to be the greatest Challenge for him/ her?	
May we share your answers with your child (circle)?    Yes                  No	