

## **ESTABLISHED PATIENT FORM**

PATIENT NAME:       DATE OF BIRTH:       AGE:       DATE;         Referring Physician:	FOLLOW-UP PATIENT NAME: D				R	ROOM #: AGE: DATE:		
HISTORY - COMPLETED BY PATIENT / PARENT         1. Reason for your visit today				DATE OF BIRTH:	AGE:			
	Re	ferring Physician:		Primary Ca	re Physician:			
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.		HIS	TORY - CON	IPLETED BY PATIE	ENT / PARENT			
No       Yes       No       Yes         Fever, weight loss, fatigue, etc.								
Eyes       Image: Construction of the patient's condition?       NO       YES         Skin       Image: Construction of the patient's condition?       Image: Construction of the patient's instruction of the patient's condition?       Image: Construction of the patient's instruction of the patient's condition?         4. Are the patient HAD ALLERGIC REACTIONS?       INO       YES         If yes, please describe:       If yes, please describe:       Image: Patient is patient's condition?       Image: Patient is patient's condition?         7. Since your last visit, please note any changes to: Surgeries Performed, Cardiac Cath's Performed, Cardiac Ablation Health of a Family Member:       Image: Patient is please note any changes to: Surgeries Performed, Cardiac Cath's Performed, Cardiac Ablation Health of a Family Member:         Image: Patient live with? (Mom, Dad, Sister, Brother, Spouse, etc.)       Image: Patient is plate in the plate in the plate in the plate in thealth of a Family Membe	2.	Please indicate if you (the patient) are h			signs or symptoms in any of th			
Skin       Image: Construct to the state of		Fever, weight loss, fatigue, etc.			Neurological			
Ears, Nose, Throat Image: Thyroid / Endocrine   Stomach / Digestion Psychiatric   Lungs / Breathing Blood / Lymph   Heart / Circulation Other   Muscle / Joints / Bones Other   Last Dental Visit:   Last Dental Visit:   Is the patient menstruating?   NO   YES   No   YES   If yes, please describe:   6. Are there any concerns about any changes in the patient's condition?   NO   YES   If yes, please note any <u>changes</u> to: Surgeries Performed, Cardiac Cath's Performed, Cardiac Ablation   Heath of a Family Member:		Eyes			Allergies			
Stomach / Digestion Psychiatric   Lungs / Breathing Blood / Lymph   Heart / Circulation Other   Muscle / Joints / Bones Other     Last Dental Visit:   Last Dental Visit:   Is the patient menstruating?   NO   YES   A Are the patient's immunizations up to date? YES If yes, please describe: 6. Are there any concerns about any changes to: Surgeries Performed, Cardiac Cath's Performed, Cardiac Ablation Health of a Family Member: 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		Skin			Urinary / Reproductive			
Lungs / Breathing Blood / Lymph   Heart / Circulation Other   Muscle / Joints / Bones Other     Last Dental Visit:   Last Dental Visit:   Is the patient menstruating? NO YES   Is the patient menstruating?   NO YES   Present medications:		Ears, Nose, Throat			Thyroid / Endocrine			
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   If yes, please describe:     6. Are there any concerns about any changes in the patient's condition?   NO   YES   If yes, please describe:     7. Since your last visit, please note any <u>changes</u> to: Surgeries Performed, Cardiac Cath's Performed, Cardiac Ablation   Health of a Family Member:   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		Stomach / Digestion			Psychiatric			
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   If yes, please describe:   6. Are there any concerns about any changes in the patient's condition?   NO   YES   If yes, please describe:   7. Since your last visit, please note any <u>changes</u> to: Surgeries Performed, Cardiac Cath's Performed, Cardiac Ablation Health of a Family Member:   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		Lungs / Breathing			Blood / Lymph			
Last Dental Visit:   Is the patient menstruating?   NO   YES   Last menstrual period:   3. Present medications:   4. Are the patient's immunizations up to date?   If yes   If yes, please describe:   6. Are there any concerns about any changes in the patient's condition?   NO   YES   If yes, please describe:   7. Since your last visit, please note any changes to: Surgeries Performed, Cardiac Cath's Performed, Cardiac Ablation Health of a Family Member:   Any forms to be completed? (FMLA, Physical, School note, etc.)   Patient / Legal Guardian Signature Date		Heart / Circulation			Other			
Is the patient menstruating? NO YES Last menstrual period:		Muscle / Joints / Bones			Other			
<ul> <li>3. Present medications:</li></ul>		Last Dental Visit:						
4. Are the patient's immunizations up to date? YES   Are the patient's immunizations up to date? NO   5. HAS THE PATIENT HAD ALLERGIC REACTIONS? NO   If yes, please describe: NO   6. Are there any concerns about any changes in the patient's condition? NO YES If yes, please describe: 7. Since your last visit, please note any changes to: Surgeries Performed, Cardiac Cath's Performed, Cardiac Ablation Health of a Family Member: 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		Is the patient menstruating? INO IYES Last menstrual period:						
<ul> <li>5. HAS THE PATIENT HAD ALLERGIC REACTIONS?</li> <li>If yes, please describe:</li> <li>6. Are there any concerns about any changes in the patient's condition?</li> <li>NO</li> <li>YES</li> <li>If yes, please describe:</li> <li>7. Since your last visit, please note any <u>changes</u> to: Surgeries Performed, Cardiac Cath's Performed, Cardiac Ablation</li> <li>Health of a Family Member:</li> <li>8. Who does the patient live with? (Mom, Dad, Sister, Brother, Spouse. etc.)</li> <li>Any forms to be completed? (FMLA, Physical, School note, etc.)</li> <li>Patient / Legal Guardian Signature</li> </ul>	3.	Present medications:						
<ul> <li>5. HAS THE PATIENT HAD ALLERGIC REACTIONS?</li> <li>If yes, please describe:</li> <li>6. Are there any concerns about any changes in the patient's condition?</li> <li>NO</li> <li>YES</li> <li>If yes, please describe:</li> <li>7. Since your last visit, please note any <u>changes</u> to: Surgeries Performed, Cardiac Cath's Performed, Cardiac Ablation</li> <li>Health of a Family Member:</li> <li>8. Who does the patient live with? (Mom, Dad, Sister, Brother, Spouse. etc.)</li> <li>Any forms to be completed? (FMLA, Physical, School note, etc.)</li> <li>Patient / Legal Guardian Signature</li> </ul>								
<ul> <li>5. HAS THE PATIENT HAD ALLERGIC REACTIONS?</li> <li>If yes, please describe:</li> <li>6. Are there any concerns about any changes in the patient's condition?</li> <li>NO</li> <li>YES</li> <li>If yes, please describe:</li> <li>7. Since your last visit, please note any <u>changes</u> to: Surgeries Performed, Cardiac Cath's Performed, Cardiac Ablation</li> <li>Health of a Family Member:</li> <li>8. Who does the patient live with? (Mom, Dad, Sister, Brother, Spouse, etc.)</li> <li>Any forms to be completed? (FMLA, Physical, School note, etc.)</li> <li>Patient / Legal Guardian Signature</li> </ul>		Are the natient's immunizations up to date	<u>_</u> ?		S D NO			
If yes, please describe:								
If yes, please describe:								
7. Since your last visit, please note any <u>changes</u> to: Surgeries Performed, Cardiac Cath's Performed, Cardiac Ablation Health of a Family Member:	6.	Are there any concerns about any changes in the patient's condition? 🗅 NO 🛛 YES						
Health of a Family Member:		If yes, please describe:						
Health of a Family Member:								
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		•						
Any forms to be completed? (FMLA, Physical, School note, etc.) Patient / Legal Guardian Signature Date								
Any forms to be completed? (FMLA, Physical, School note, etc.) Patient / Legal Guardian Signature Date	8	Who does the patient live with? (Mom. Da	d Sister Bro	ther Spouse etc.)				
Patient / Legal Guardian Signature Date								
	Ar	y forms to be completed? (FMLA, Physical, Sch	ool note, etc.)					
Physician Signature Date	Patient / Legal Guardian Signature				Date			
	Pł	ysician Signature		Date				