PHOENIX CHILDREN'S *Medical Group*®

FOLLOW UP PATIENT MEDICAL INFORMATION

Apply Patient Label

REVIEW OF SYSTEMS (ANY PROBLEMS WITH):

Constitutional (Fever, unexplained weight loss, masses)	No ☐	Yes ☐*
Eyes (Blurred Vision)	No ☐	Yes ☐*
Ear, Nose, Throat	No ☐	Yes ☐*
Cardiovascular System (Chest pain, shortness of breath)	No ☐	Yes ☐*
Respiratory System (Asthma, Cough)	No ☐	Yes ☐*
Neurologic System (Numbness, Tingling in arms or legs)	No ☐	Yes ☐*
Gastrointestinal system (Abdominal Pain, Nausea)	No ☐	Yes ☐*
Genitourinary System (Menstrual Irregularity, Urinary)	No ☐	Yes ☐*
Hematologic/Lymphatic (Anemia, Blood Disorders, Immune System)	No ☐	Yes ☐*
Endocrine System (Diabetes, Thyroid)	No ☐	Yes ☐*
Psychiatric (Depression, Anxiety)	No ☐	Yes ☐*
Allergic/Immunologic (Eczema, Hives, Recurrent Infections)	No ☐	Yes ☐*
Musculoskeletal	No ☐	Yes ☐*

****If you marked yes above, please explain problem in more detail here:**

Do you have any concerns that you would like to discuss with the provider today?

_____

_____

_____

_____ _____

Signature of Patient/Legally Authorized Representative **Relationship to Patient**

_____ _____ _____

Printed Name of Patient/Legally Authorized Representative **Date** **Time**

BELOW FOR STAFF USE ONLY

Physician Notes

_____ _____ _____ _____

Practitioner Signature Practitioner Printed Name Date Time

1919 E. Thomas Rd. Main Bldg 2nd Floor ▪ Phoenix, AZ 85016 ▪ (P) 602-933-3033 ▪ (F) 602-933-5245