

Shailesh M. Asaikar, MD  
Paul M. Chretien, MD  
Virginia Lee, MD  
1111 Exposition Blvd.,  
Bldg. 700, Suite 102  
Sacramento, CA 95815  
Phone: (916) 649-9800  
Fax: (916) 649-9801

Child and Adolescent Neurology Consultants

# Revisiting Patients

Childs Name: \_\_\_\_\_ Height: \_\_\_\_\_ Age: \_\_\_\_\_  
Date: \_\_\_\_\_ Weight: \_\_\_\_\_  
Name of Person Completing Form: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Email address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone 1: \_\_\_\_\_ Cell Phone 2: \_\_\_\_\_

Reason for followup/Diagnosis:

---

---

Present Medications (please indicate names and doses):

---

---

Do you need refills of any medication(s)?  Yes/No

Name of Medication: \_\_\_\_\_

Pharmacy: \_\_\_\_\_

Allergies: \_\_\_\_\_

## 8) Review of systems (Check where appropriate) Do you have problems with:

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Headaches?           | <input type="checkbox"/> Bleeding troubles? | <input type="checkbox"/> Chest pain?       | <input type="checkbox"/> Bowel movements? |
| <input type="checkbox"/> Seizures?            | <input type="checkbox"/> Numbness?          | <input type="checkbox"/> Smell or taste?   | <input type="checkbox"/> Easy bruising?   |
| <input type="checkbox"/> Abnormal heartbeats? | <input type="checkbox"/> Bladder troubles?  | <input type="checkbox"/> Weakness?         | <input type="checkbox"/> Dizziness?       |
| <input type="checkbox"/> Vision?              | <input type="checkbox"/> Breathing?         | <input type="checkbox"/> Stomach troubles? | <input type="checkbox"/> Skin troubles?   |
| <input type="checkbox"/> Swallowing?          | <input type="checkbox"/> Sleep?             | <input type="checkbox"/> Hearing?          | <input type="checkbox"/> Asthma?          |
| <input type="checkbox"/> Weight?              | <input type="checkbox"/> Blackouts?         | <input type="checkbox"/> Appetite?         | <input type="checkbox"/> Balance?         |
| <input type="checkbox"/> Anxiety?             | <input type="checkbox"/> Depression?        |  |   |