Returning Patient Questionnaire

DUKE CHILDREN'S CARDIOLOGY OF RALEIGH
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If necessary, please update your contact information:

Patient's Name____**DOB**_________

Address: ____

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Phone: __________________________________ **Work phone:** ______________________________

Cell phone: ______________________________ **E-mail:** __________________________________

Has your pediatrician or primary care provider changed? __ Yes __ No

If "yes," please provide name of new provider: ____

Please provide name of new practice: ____

Does the patient see any other pediatric specialists? __ Yes __ No

If "yes," please list them: ____

Has the patient had any new medical problems since the last visit? __ Yes __ No

If "yes," please explain: ____

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Has the patient had surgery since the last visit? __ Yes __ No

If "yes," please explain: ____

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Has the patient been hospitalized since the last visit? __ Yes __ No

If "yes," please explain: ____

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Are the patient's immunizations up-to-date? __ Yes __ No

Is the patient in daycare/preschool/school? __ Yes __ No __ N/A

If the patient is in school, what grade? ____

Does the patient exercise regularly? __ Yes __ No __ N/A

Please list organized sports and other activities: ____

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____ _____________________

Signature of parent, guardian or patient (if 18 years or older) **Date**

____

Printed name

Revised 7/11/11