McLaren Ambulatory Care Center

ADHD/BEHAVIORAL MED FOLLOW-UP VISIT

Patient's Current Age:__________ Allergies:___________________

Reason for today's visit:____

Any concerns or questions: ______________________________________

____

HISTORY OF PROBLEM:

Current medications (include name, dose, and time given):

____

____

____

How long has the child been on this medication regimen?____________

Side effects of medication:

- ❑ Loss of appetite
- ❑ Difficulty falling asleep
- ❑ Excessive irritability
- ❑ Listlessness
- ❑ Social withdrawal
- ❑ Abdominal pain/headache

Other:____

____

Any problems with stooling or urination? ❑ Yes ❑ No _____________

What time does the child go to bed?____________ Get up?_________

How long does it take the child to fall asleep?_________________

How many hrs/day watching TV/computer/video games?____________

School Performance:

School Name:____

Grade:____________ ❑ Regular Ed ❑ Special Ed

What kind of help are they getting?____________________________

____

Academic performance/grades:___________________________________

Behavioral/social problems in school?__________________________

____

Extracurricular activities/hobbies:____________________________

Counseling:____

College plans: ____

Part-time job:________________________________Hrs/week:______

Driving problems:____

Has the child ever used tobacco, alcohol, or illicit drugs? ❑ Yes ❑ No

Has the child ever had sexual intercourse? ❑ Yes ❑ No

How many good friends does the child have? ___________

For girls, date of first period_________ Date of last period__________

How often are periods?____________ How long do they last?_______

Any problems with periods, cramps, etc.? ❑ Yes ❑ No

____

Above information was completed by:

____

Name (signature) Relationship to Patient

ROS: See questionnaire

Past Medical History: ❑ Unchanged ______________________

Family History: ❑ Unchanged ______________________

Social History: See questionnaire

PHYSICAL EXAM:

Weight:____________ Height:____________ BMI:_____________

Temp:________ Pulse:________ Resp:________ BP:____________

Vision:		Hearing:	500 dB	1000 dB	2000 dB	4000 dB
OU 20/_______		R	______	______	______	______
OD 20/_______		L	______	______	______	______
OS 20/_______						

	NORMAL	FINDINGS
General Appearance	❑	____________
Skin	❑	____________
Head	❑	____________
Eyes	❑	____________
Ears	❑	____________
Nose	❑	____________
Mouth/Pharynx	❑	____________
Neck	❑	____________
Chest	❑	____________
Heart	❑	____________
Lungs	❑	____________
Abdomen	❑	____________
Genitalia	❑	____________
❑ Male/Testes Down		____________
❑ Female		____________
❑ Tanner Stage		____________
Musculoskeletal	❑	____________
Neurological	❑	____________

ASSESSMENT: ____

____

____

____

PLAN: ❑ Continue current medication

❑ CBC ❑ SGOT ❑ UA ❑ EKG

❑ > 50% of office visit dominated by counseling/education

Rx:____

____

____

Referrals:____

FOLLOW UP: ❑ In 6 months ❑ Other: ________________

____

Clinical Staff Signature Date

____

Provider Signature Date

PATIENT NAME:

DATE OF BIRTH: