

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: _____

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: _____

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

If "yes," please explain: _____

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

If "yes," please explain: _____

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: _____

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

Date

Printed name

Revised 7/11/11