Advocate Medical Group
Adult Down Syndrome Center

RETURNING PATIENT HEALTH QUESTIONNAIRE

Date and Time of Appointment ____

ALL QUESTIONS REFER TO THE PERSON WITH DOWN SYNDROME

Name ____ Date of Birth ___________________

Person Filling Out the Form and Relationship to Person with Down Syndrome: ___________________________________

Do you have any specific concerns regarding new or ongoing health/behavioral issues about the person with Down syndrome? (Please write in the space below. Use another sheet of paper if necessary).

____

____

SINCE LAST APPOINTMENT, PLEASE LIST ANY CHANGES IN:

Residence/Family/Living Situation (including change in Legal Guardian) None _____

____

____

School/Work None _____

____

____

Activities/Interests None _____

____

____

Exercise None _____

____

____

Diet/Weight None _____

Sleep None _____

Stressors None _____

OTHER UPDATES:

Does the person with Down syndrome have difficulty with blood draws or injections? **If yes,** please describe:

If you would like to discuss strategies to improve the experience, please call our office and ask to speak to our nursing staff.

Are there any new medical conditions/surgeries/hospitalizations/testing? None _____

PLEASE PROVIDE DATES/REPORTS FOR:

Last eye examination ____________________ None _____

Last hearing examination ____________________ None _____

Last dental examination ____________________ None _____

PLEASE BRING THE FOLLOWING TO THE APPOINTMENT:

- An updated Allergy/Medication list.
- Any results from recent labs.
- The names and dates of any recent immunizations.

Do you have any forms that need to be completed? Yes _____ No _____