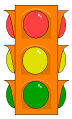

THE PEDIATRIC CLINIC
QUARTERLY MEDICATION REVIEW

Child's Name: _____ Date of Birth: _____

Your child has been prescribed a medication with potential adverse side effects.
The following questions allow the provider to better monitor theses concerns.

I would like a conference with _____ to discuss my child's medication/progress YES NO

Side Effects: Has your child experienced any of the following side effects or problems in the past weeks?	Are these side effects currently a problem?			
	None	Mild	Moderate	Severe
Headache				
Stomachache				
Unusual change in appetite				
Trouble sleeping				
Irritability				
Obsessive behaviors				
Socially withdrawn – decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaking				
Repetitive movements, tics, jerking, eye-blinking				
Picking @ skin/fingers, nail biting, lip or cheek chewing				
Sees or hears things that aren't there				
Other Concerns:				

I understand that my child's medication is a controlled substance and requires a physical examination and physician follow-up *every six months*.
Schedule your next exam today.

Last PE: _____ Next PE : _____

Signature: _____ Relationship to patient: _____

We suggest for requesting refills, use our website:
www.thepediatricclinicorangeburg.com
or email us: **thepediatricclinic@ntinet.com**

Office Use: This form is to be reviewed by: _____