REVIEW OF SYSTEMS

Please check if your child has a history of any of the following: All systems negative: _____

Patient: _____

Date: _____/_____/_____ DOB: _____/_____/_____

General:

- Poor weight gain
- Recent weight loss
- Frequent fevers
- Fatigue (tiredness)
- Paleness

Respiratory:

- Wheezing
- Coughing
- Chest pain
- Difficulty catching breath
- Problems with sleep or snoring
- Fast breathing

Gastrointestinal:

- Coughing/choking/gagging when eating
- Frequent vomiting
- Constipation
- Frequent heartburn/stomachaches
- Frequent diarrhea/loose stools

Cardiovascular:

- Problems with heart
- High blood pressure
- Heart mummer
- Blue spells
- Swelling in hands/feet
- Irregular heartbeat

Skin:

- Eczema
- Rashes
- Itching, dryness
- Birthmarks
- Areas with abnormal pigment

Known Medication Allergies:

- _____
- _____
- _____

Neurologic:

- Headaches
- Seizures
- Weakness
- Problems in school
- Speech problems
- Vision problems
- Paralysis
- Loss of memory/confusion
- Frequent falls

Musculoskeletal:

- Limpness
- Muscle pain
- Joint pain
- Joint swelling

Psychiatric:

- Mood swings
- Nervousness
- Sleep disturbances
- Depression
- Temper outbursts

Other symptoms:

- Heat or cold intolerance
- Excessive/night sweats
- Excessive hunger
- Excessive thirst
- Frequent/excessive urination
- Anemia
- Easy bruising/bleeding
- Seasonal allergies/hay fever
- Food allergies
- Head congestion
- Nosebleeds
- Weak cry/ voice
- Loss of taste/smell
- Frequent ear infections
- _____

Doctor's Signature: _____