



Review of Systems

Patient Name: _____

Date of Birth: _____

New Patients: Apart from the reason for today's visit, please check any conditions that apply to your child.

Established Patients: Only check conditions that have not already been addressed or that you want to discuss.

Constitutional

- failure to thrive, fatigue, unexplained fevers
- obesity or unusual/unexpected weight change

Skin

- unusual moles, rashes, or skin lesions
- chronic eczema not currently being treated

Eyes/ Ears/Nose/Throat

- vision or hearing problems
- "lazy eye" or eyes crossing
- chronic persistent history of snoring
- speech concerns not already being addressed

Cardiovascular/Respiratory

- cyanotic episodes (blue or purple skin color)
- unusually poor exercise tolerance
- apnea episodes (temporary cessation of breathing)
- chronic cough for more than 3-4 weeks
- difficulty breathing, wheezing, or chest tightness

Gastrointestinal

- recurrent or chronic abdominal pain
- chronic constipation, diarrhea, or soiling
- pica (eats dirt/paint/plaster/clay)
- food intolerances- _____
- feeding or swallowing issues
- recurrent vomiting or reflux

Musculoskeletal

- unusual limb pain, joint pain, or swelling
- curved spine
- problems with walking or balance

Genitourinary

- painful urination
- enuresis (involuntary urination/bedwetting)
- blood in the urine
- unusual vaginal discharge
- known/suspected sexual abuse

Psych/Behav/Sleep

- suspected alcohol/drug/tobacco use?
- school, behavior, or discipline problems
- depression, anxiety, or mood disorders
- personality change
- nightmares (frequent) or other sleep disturbance
- symptoms of ADD/ADHD

Endocrine

- early or delayed puberty
- excessive thirst or urination
- concerns about height or growth rate

Neurological

- breath-holding spells
- developmental delay
- dizziness, vertigo, or fainting
- recurrent headaches not previously discussed
- seizures, staring spells, or involuntary movements

Other Conditions or Concerns

- _____
- _____

ALLERGIC REACTIONS

(list significant allergic reactions to meds, foods, insects, etc.)

LEAD SCREENING

- live in or frequently visit a house built before 1960
- frequent exposure to a house built before 1978 with recent, ongoing, or planned renovation/remodeling
- known exposure to family member or playmate being followed or treated for lead poisoning
- frequent contact with adult in the following fields:
(construction; welding; auto repair; stained glass; use of lead based solder, paints, ceramic glazes, etc.)
- has taken home remedies containing lead

TUBERCULOSIS SCREENING

- live with or close contact with person with TB
- history of positive TB test

SOCIAL CHANGES

- change in parents marital status
- new sibling(s) or change in # of people in household
- _____

OTHER

Signature: _____

Date: _____