REVIEW OF SYSTEMS

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

Patient: _____

Date: ____/____/____ DOB: ____/____/____

General:

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

Respiratory:

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

Gastrointestinal:

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

Cardiovascular:

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

Skin:

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

Known Medication Allergies:

- o _____
- o _____
- o _____

Neurologic:

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

Musculoskeletal:

- o Limpness
- o Muscle pain
- o Joint pain
- o Joint swelling

Psychiatric:

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

Other symptoms:

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

Doctor's Signature: _____

REVIEW OF SYSTEMS (RETURNS)

Patient_____

Date ___/___/___ Date of Birth ___/___/___

Please check if your child has/had (past or present) any of the following: All systems negative _____

General:

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

Eyes:

- Double vision
- Blurry vision

Ears, Nose, Mouth, Throat

- Frequent ear infections
- Nosebleeds
- Snoring

Respiratory:

- Wheezing
- Coughing
- Difficulty catching breath

Gastrointestinal:

- Coughing/choking/gagging when eating
- Frequent nausea, vomiting or diarrhea
- Constipation

Cardiovascular:

- Problems with heart
- High blood pressure
- Swelling in hands/feet
- Irregular heartbeat

Skin:

- Rashes
- Birthmarks
- Areas with abnormal pigment

Musculoskeletal:

- Limpness or weakness
- Muscle or joint pain/swelling

Hematologic:

- Anemia
- Easy bruising/bleeding

Psychiatric:

- Mood swings
- Nervousness/Anxiety
- Sleep disturbances
- Depression

Endocrine:

- Heat or cold intolerance
- Excessive/night sweats
- Excessive hunger or thirst

Allergy:

- Seasonal allergies/hayfever
- Food allergies
- Medication allergies (please list):
- _____
- _____

Since the last visit (circle yes or no, if yes, please explain):

Has the patient been to the emergency room or admitted to the hospital? YES / NO

Has the patient had surgery? YES / NO

Have there been any changes to family members living with the patient? YES / NO

Any changes to family history relevant to the patient's neurologic disease? YES / NO

Current grade level of the patient: _____

Regular classes/grade level work? YES / NO

_____

_____

_____

_____

_____

_____

_____