

Review of Systems (Returns)

Patient: _____

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

Please check if your child has a history of 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
- Snoring
- Nosebleeds

RESPIRATORY

- Wheezing
- Difficulty catching breath
- Coughing

GASTROINTESTINAL

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

CARDIOVASCULAR

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

SKIN

- Rashes
- Areas with abnormal pigment
- Birthmarks

MUSCULOSKELETAL

- Limpness or weakness
- Muscle or joint pain/swelling

HEMATOLOGIC

- Anemic
- Easy bruising/bleeding

PSYCHIATRIC

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

ENDOCRINE

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

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