

Patient's Name: \_\_\_\_\_

Name
MR#

### Review of Systems

Does your child have any of the following problems? Explain in space to right.

#### Constitutional Symptoms

Fever	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Weight changes	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Feeding/eating problems	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Headaches	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Other:	_____			

#### Eyes

Blurred / Double Vision	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Pain	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Other:	_____			

#### Allergic/Immunologic

Hay Fever	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Other:	_____			

#### Neurological

Seizures	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Weakness	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Numbness/tingling	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Other:	_____			

#### Endocrine

Excessive thirst	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Too Hot/Cold	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Tired/Sluggish	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Other:	_____			

#### Gastrointestinal

Abdominal Pain	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Nausea/Vomiting	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Constipation	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Other:	_____			

#### Cardiovascular

Chest Pain	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Heart Murmur	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
High Blood Pressure	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Other:	_____			

#### Integumentary

Skin Rash / Boils	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Lasting Itch	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Other:	_____			

#### Musculoskeletal

Joint Pain	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Neck Pain / Back Pain	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Other:	_____			

#### Ear/Nose/Throat/Mouth

Ear infection	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Sore Throat	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Sinus Problems	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Other:	_____			

#### Genitourinary

Urine Infection	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Wetting Accidents	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Urinary Frequency	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Other:	_____			

#### Respiratory

Wheezing	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Frequent Cough	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Pneumonia	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Other:	_____			

#### Hematologic/Lymphatic

Swollen Glands	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Blood Clotting Problem	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Other:	_____			

#### Psychologic

Personality changes	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Hyperactivity	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Difficulty concentrating	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Memory trouble	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
Other:	_____			

#### Physician use only.

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#	Level
0 - 1	1 or 2
2 - 9	3
10 +	4 or 5

Physician: \_\_\_\_\_ Date: \_\_\_\_\_