



PEDIATRIC REVIEW OF SYSTEMS

Patient Name: _____ **DOB:** _____

1. Constitutional Symptoms

Fever	No	Yes
Chills	No	Yes
Weight loss	No	Yes
Weight gain	No	Yes
Fatigue	No	Yes
Loss of appetite	No	Yes
Body aches	No	Yes
Night sweats	No	Yes
Birth history of prematurity	No	Yes
Is your child exposed to cigarette smoke	No	Yes
Is child in foster care	No	Yes
Do you have concerns about your child's sexual development	No	Yes

2. Eyes

Blurred vision	No	Yes
Eye pain	No	Yes
Glasses/contacts	No	Yes
Impaired vision	No	Yes

3. Head, Ears, Nose, Throat

Sinus congestion	No	Yes
Sore throat	No	Yes
Dental problems	No	Yes
Recent head injury	No	Yes
Hydrocephalus	No	Yes
Ear infections	No	Yes

4. Breasts

Tenderness	No	Yes
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5. Cardiovascular

Cardiac murmurs	No	Yes
Irregular heartbeats	No	Yes
Shortness of breath on exertion	No	Yes
Lower extremity swelling	No	Yes
Congenital heart defects	No	Yes

6. Respiratory

Shortness of breath	No	Yes
Wheezing	No	Yes
Cough	No	Yes
Sleep apnea	No	Yes
Anesthetic problems	No	Yes
TB exposure	No	Yes
Asthma	No	Yes

7. Gastrointestinal

Nausea	No	Yes
Vomiting	No	Yes
Change in abdominal girth	No	Yes
Diarrhea	No	Yes
Constipation	No	Yes
Abdominal pain	No	Yes
Jaundice	No	Yes
Blood in stool	No	Yes
Fecal incontinence	No	Yes

8. Genitourinary

Urgency	No	Yes
Frequency	No	Yes
Painful urination	No	Yes
Blood in urine	No	Yes
Change in urine color	No	Yes
Incontinence	No	Yes
Urinary retention	No	Yes
Difficulty urinating	No	Yes
Decreased stream	No	Yes
Painful periods	No	Yes
Scrotal pain	No	Yes

9. Integument

Rash	No	Yes
Itching	No	Yes
New skin lesions	No	Yes
Pigmentation changes	No	Yes
Excessive hair growth in unusual places	No	Yes

Please complete other side.

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| 10. | <u>Neurologic</u> | | |
| | Muscular weakness | No | Yes |
| | Memory difficulties | No | Yes |
| | Speech difficulties | No | Yes |
| | Headache | No | Yes |
| | Seizures | No | Yes |
| | Tremors | No | Yes |
| | Loss of balance | No | Yes |
| 11. | <u>Musculoskeletal</u> | | |
| | Back pain | No | Yes |
| | Joint pain | No | Yes |
| | Muscle pain | No | Yes |
| | Limitation of motion | No | Yes |
| | Muscular weakness | No | Yes |
| 12. | <u>Endocrine</u> | | |
| | Excessive urination (volume) | No | Yes |
| | Always thirsty | No | Yes |
| | Central obesity | No | Yes |
| 13. | <u>Psychiatric</u> | | |
| | Anxiety | No | Yes |
| | Depression | No | Yes |
| | Difficulty sleeping | No | Yes |
| | Suicidal thoughts | No | Yes |
| 14. | <u>Hematologic/Lymphatic</u> | | |
| | Easy bleeding | No | Yes |
| | Bruise easily | No | Yes |
| | Lymph node enlargement | No | Yes |
| 15. | <u>Allergic-Immunologic</u> | | |
| | Sinus allergy symptoms | No | Yes |
| | Skin allergy resulting in rash | No | Yes |

Patient/Guardian Signature: _____

Date: _____