ALASKA UROLOGY

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
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. **Neurologic**

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. **Musculoskeletal**

Back pain	No	Yes
Joint pain	No	Yes
Muscle pain	No	Yes
Limitation of motion	No	Yes
Muscular weakness	No	Yes

12. **Endocrine**

Excessive urination (volume)	No	Yes
Always thirsty	No	Yes
Central obesity	No	Yes

13. **Psychiatric**

Anxiety	No	Yes
Depression	No	Yes
Difficulty sleeping	No	Yes

14. **Hematologic/Lymphatic**

Easy bleeding	No	Yes
Bruise easily	No	Yes
Lymph node enlargement	No	Yes

15. **Allergic-Immunologic**

Sinus allergy symptoms	No	Yes
Skin allergy resulting in rash	No	Yes

Patient/Guardian Signature:_____

Date: _____/_____/_____