	REVIEW OF SYSTEMS/MEDICAL UPDATE **CHILD**

IN THE PAST MONTH, HAS YOUR CHILD EXPERIENCED ANY OF THESE PROBLEMS:

General, constitutional

Recent weight change	NO	YES
Fever	NO	YES
Fatigue	NO	YES

Eyes and vision

Eye injury	NO	YES
Glasses or contacts	NO	YES
Blurred or double vision	NO	YES
Glaucoma	NO	YES

Ears, nose, throat

Hearing loss	NO	YES
Ringing in the ears	NO	YES
Sinus problems	NO	YES
Nose bleeds	NO	YES
Mouth sores	NO	YES
Bleeding gums	NO	YES
Bad breath or bad taste	NO	YES
Sore throat or voice change	NO	YES

Heart and cardiovascular

Heart trouble	NO	YES
Chest pains	NO	YES
Sudden heartbeat changes	NO	YES

Respiratory

Frequent coughing	NO	YES
Shortness of breath	NO	YES
Asthma or wheezing	NO	YES

Gastrointestinal

Loss of appetite	NO	YES
Change in bowel movements	NO	YES
Nausea or vomiting	NO	YES
Frequent diarrhea	NO	YES
Painful bowel movements/constipation	NO	YES
Blood in stool	NO	YES
Stomach pain	NO	YES

Genitourinary

Frequent urination	NO	YES
Burning or painful urination	NO	YES
Blood in urine	NO	YES
Urine accidents	NO	YES
Kidney stones	NO	YES
Female: Painful periods	NO	YES
Female: Irregular periods	NO	YES
Female: Vaginal discharge	NO	YES

Parent or patient sign here:

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Musculoskeletal

Joint pain	NO	YES
Joint stiffness or swelling	NO	YES
Weakness of muscles/joints	NO	YES
Muscle pain or cramps	NO	YES
Back pain	NO	YES

Skin and breasts

Rash or itching	NO	YES
Change in skin color	NO	YES
Change in hair or nails	NO	YES
Dry skin	NO	YES
Breast lump	NO	YES
Breast discharge	NO	YES

Neurological

Frequent or recurrent headaches	NO	YES
Lightheaded or dizzy	NO	YES
Convulsions or seizures	NO	YES
Numbness or tingling sensations	NO	YES
Tremors	NO	YES
Weakness	NO	YES
Head injury	NO	YES

Psychiatric

Nervousness	NO	YES
Depression	NO	YES
Sleep problems	NO	YES

Endocrine

Glandular or hormone problem	NO	YES
Thyroid disease	NO	YES
Diabetes	NO	YES
Excessive thirst or urination	NO	YES
Heat or cold intolerance	NO	YES

Hematology/Lymphatic

Slow to heal after cuts	NO	YES
Easy bruising or bleeding	NO	YES
Anemia	NO	YES
Transfusion	NO	YES
Swollen glands	NO	YES

Please give the date of last menstrual period.

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Physician/PA sign here:

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