

Patient History and Review of Systems
(under 18 years of Age)

Name: _____ Date: _____

Check if you have the following:

GENERAL

- Fever
- Chills
- Sweats
- Anorexia
- Fatigue/Weakness
- Malaise
- Weight Loss
- Sleep Disorder

EYES

- Blurring
- Double Vision
- Eye Irritation
- Eye Discharge
- Vision Loss
- Eye Pain
- Light Sensitivity

EARS, NOSE AND THROAT

- Earache
- Ear Discharge
- Ringing in Ears
- Decreased Hearing
- Nasal Congestion
- Nosebleeds
- Sore Throat
- Hoarseness

CARDIOVASCULAR

- Chest Pain
- Bluish Color Lips/Nails
- Difficulty Breathing with Exertion
- Palpitations
- Peripheral Edema
- Fainting

RESPIRATORY

- Cough
- Cough with Exercise
- Difficulty Breathing at Rest
- Excessive Sputum
- Coughing up Blood
- Nighttime Cough/Wheeze
- Wheezing

GASTROINTESTINAL

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Change in Bowel Habits
- Abdominal Pain
- Dark, Tarry Stools
- Bloody Stools
- Yellow Skin Color
- Gas/Bloating
- Indigestion/Heartburn
- Difficulty Swallowing

GENITOURINARY

- Vaginal Discharge
- Incontinence
- Daytime Urination
- Nighttime Urination
- Painful Urination
- Blood in Urine
- Urinary Frequency
- Abnormal Periods
- Painful Periods
- Abnormal Vaginal Bleeding
- Pelvic Pain
- Genital Sores

MUSCULOSKELETAL

- Back Pain
- Joint Pain
- Joint Swelling
- Muscle Cramps
- Muscle Weakness
- Stiffness
- Arthritis
- Low Back Pain
- Restless Legs
- Leg Pain at Night
- Leg Pain with Exertion

DERMATOLOGICAL

- Rash
- Itching
- Dryness
- Suspicious Lesions

NEUROLOGICAL

- Abnormal Walking
- Frequent Falls
- Frequent Headaches
- Increased Tone in Limbs
- Paralysis
- Numbness or Tingling
- Seizures
- Tremors
- Poor Balance
- Weakness of Limbs

PSYCHOLOGICAL

- Anxiety
- Behavioral Problems
- Combative
- Compulsive Behavior
- Depression
- Hyperactivity
- Inattentive
- Obsessive Behavior
- Paranoia
- Frightening Visions/Sounds
- Thoughts of Suicide
- Temper Tantrums

ENDOCRINE

- Cold Intolerance
- Heat Intolerance
- Excessive Thirst
- Excessive Hunger
- Excessive Urination
- Unusual Weight Change

HEMATOLOGY

- Abnormal Bruising
- Bleeding
- Enlarged Lymph Nodes

ALLERGY

- Hives
- Allergic Rash
- Hay Fever
- Recurrent Infections

Young Women (if applicable):

1. Age first period _____
2. Date of last period _____
3. Pelvic or vaginal infection _____
4. Contraception used _____
5. # of Pregnancies: _____
 Miscarriage _____ Abortion _____
6. Last Pap _____ Result _____

Medical Conditions: _____ Date _____

Bring list of medication or note below

Medications _____ Dose _____

Allergies: _____

Surgeries & Hospitalizations: _____ Date _____

Risk Factors:

1. Does anyone smoke in your home? _____
 2. Exercise: Frequency/week _____
 Type _____
 3. Seatbelt/Car Seat Use?: yes no
 4. Sun Screen Use?: yes no
 5. Immunizations Current?: yes no
- If no, please explain:

Family History: _____ Who: _____

1. Alcoholism _____
2. Arthritis _____
3. Asthma _____
4. Bleeding Disorder _____
5. Breast Cancer _____
6. Cervical Cancer _____
7. Coronary Heart Disease(CHD) _____
8. CHD (male < 55yrs) _____
9. CHD (female <65yrs) _____
10. Colon Cancer _____
11. Colon Cancer-Father _____
12. Colon Cancer-Mother _____
13. Colon Polyps _____
14. Depression _____
15. Diabetes _____
16. Cerebral Vascular Accident/Stroke _____
17. Hypertension _____
18. High Cholesterol _____
19. Lung Cancer _____
20. Melanoma _____
21. Migraines _____
22. Osteoporosis _____
23. Ovarian Cancer _____
24. Pancreatic Cancer _____
25. Prostate Cancer _____
26. Kidney Disease _____
27. Seizures _____
28. Skin Cancer _____
29. Suicide _____
30. Thyroid Disease _____
31. Huntington's Disease _____
32. Learning Disabilities _____
33. ADD _____
34. ADHD _____
35. Birth Defects _____
36. Growth/Development _____
37. Sexually Transmitted Disease _____
38. Weight Disorder _____
39. Neg Family History Breast Cancer _____
40. Neg Family History Cervical Cancer _____
41. Neg Family History Colon Cancer _____
42. Neg Family History Diabetes _____
43. Neg Family History Hypertension _____
44. Neg FH Diabetes/Hypertension/Coronary Artery Disease _____