Patient's Name_____ **DOB** _____ **Today's Date**_____

REVIEW OF SYSTEMS (Please check if your child <u>currently</u> is suffering from any of the following):

Constitutional

Fever ___ Fatigue ___ Headache ___

Eyes

Blurred Vision ___ Double Vision ___ Glasses ___

Ears / Nose / Throat

Ear Infection ___ Throat Infection ___ Sinus Infection ___

Respiratory

Wheezing ___ Pneumonia ___ Cough ___

Intestinal

Nausea ___ Vomiting ___ Stomach Pain ___ Stomach Swelling ___

Musculoskeletal

Joint Pain ___ Joint Swelling ___ Muscle Pain ___ Back Pain ___

Neurological

Seizure ___ Leg Pain ___ Leg Weakness ___

Endocrine

Excessive Thirst ___ Weight Loss ___ Weight Gain ___

Cardiovascular

Chest Pain ___ Palpitations ___ Heart Murmur ___

Hematological / Lymphatic

Easy Bleeder ___ Swollen Glands ___

Immunologic

Hay Fever ___ Environmental Allergies ___