ANNUAL CHILDREN REVIEW OF SYSTEMS

Name: ___________________________DOB___/____/___ Today's Date___/____/____

Recent Procedures:____

New Medical Problems: ____

Review of Systems ***Please check any current problems / symptoms within the <u>last 30 days</u>***

<u>**General**</u> ☐ **NO PROBLEMS**	☐fever ☐lethargy ☐weight loss _____ ☐weight gain _____ ☐weakness	<u>**Genitourinary**</u> ☐ **NO PROBLEMS**	☐painful urination ☐increased frequency ☐urinary urgency ☐blood in urine ☐incontinence accidents ________ ☐urinary tract infections ☐kidney stones
<u>**Heart**</u> ☐ **NO PROBLEMS**	☐chest pain ☐fainting	<u>**Male reproductive**</u> ☐ **NO PROBLEMS**	☐testicular pain ☐swelling
<u>**Lungs**</u> ☐ **NO PROBLEMS**	☐cough ☐shortness of breath ☐recent cold ☐wheezing ☐asthma	<u>**Female reproductive**</u> ☐ **NO PROBLEMS**	☐Last menstrual period_____ ☐Currently pregnant Number of pregnancies_______
<u>**Gastrointestinal (GI)**</u> ☐ **NO PROBLEMS**	☐abdominal pain ☐nausea & vomiting ☐diarrhea ☐constipation	<u>**Nervous / Psychiatric**</u> ☐ **NO PROBLEMS**	☐headaches ☐depression ☐ anxiety
<u>**Eyes Ears Nose Mouth**</u> ☐ **NO PROBLEMS**	☐vision change ☐dizziness	<u>**Hematologic/Infectious**</u> ☐ **NO PROBLEMS**	☐easy bleeding ☐C Diff Date:__________ ☐MRSA Date:__________
<u>**Skin**</u> ☐ **NO PROBLEMS**	☐itching ☐rash ☐open wound/poor healing		