Do not write, stamp, punch holes or affix a sticker in this area.

Direction of Feed

Review Of Systems Pediatric

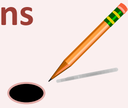
Please answer every question

To reproduce, follow the printing instructions. Do not fold this form.

Marking Instructions

Please use a # 2 pencil

Fill in the complete oval as shown...



PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Has your child had any problems with or do you have concerns with any of the following?

Mark all that apply. If no symptoms, please mark "NONE."

General

- fatigue
- fevers / chills / excessive sweating
- unexplained weight loss / gain
- NONE

Eyes

- eye discharge
- squinting or "crossed" eyes
- NONE

Ears / Nose / Throat

- unusually loud voice / hard of hearing
- frequent runny nose
- mouth breathing / snoring
- frequent ear infections / ear pain
- bad breath
- frequent sore throats
- problems with teeth / gums
- frequent colds
- nose bleeds
- NONE

Respiratory

- difficulty breathing
- cough
- wheezing
- NONE

Gastrointestinal

- diarrhea
- nausea / vomiting
- abdominal pain
- constipation
- blood in bowel movement
- NONE

Cardiovascular

- shortness of breath
- tires easily with exertion
- fainting
- NONE

Genitourinary

- bedwetting
- pain with urination
- discharge from penis or vagina
- NONE

Muscular / Skeletal

- muscle or joint pain
- NONE

Allergy

- hay fever / itchy eyes
- NONE

Skin

- rash(es)
- unusual mole(s)
- NONE

Emotional

- depression
- speech problem(s)
- nail biting / thumb sucking
- problem(s) with sleep / nightmares
- headaches
- bad temper / breath holding / jealousy
- anxiety / stress
- NONE

Blood / Lymph

- unexplained lump(s)
- easy bruising / bleeding
- NONE

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SAMPLE

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