Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Review of Systems
Pediatric

Please answer every question.

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

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
- NONE

Ears / Nose / Throat

- frequent hoarseness
- 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
- NONE

Cardiovascular

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

Genitourinary

- bedwetting
- NONE

Muscular / Skeletal

- muscle or joint pain
- NONE

Allergy

- hay fever / itchy eyes
- NONE

Skin

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

Emotional

- speech problem(s)
- headaches
- problem(s) with sleep / nightmares
- behavior problems at school
- NONE

Blood / Lymph

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