EAST TENNESSEE Children's Hospital

Review of Systems

Patient: _____

Date:____/____/____ Date of Birth: ____/____/____

Please check if your child has a history of any of the following:

All systems negative _____

GENERAL

- ☐ Poor weight gain
- ☐ Recent weight loss
- ☐ Frequent fevers
- ☐ Fatigue (tiredness)
- ☐ Paleness

NEUROLOGIC

- ☐ Headaches
- ☐ Seizures
- ☐ Weakness
- ☐Problems in school
- ☐ Speech problems
- ☐ Vision problems
- ☐ Paralysis
- ☐ Loss of memory/confusion
- ☐ Frequent falls

RESPIRATORY

- ☐ Wheezing
- ☐ Coughing
- ☐ Chest Pain
- ☐ Difficulty catching breath
- ☐ Problems with sleep or snoring
- ☐ Fast breathing

MUSCULOSKELETAL

- ☐ Limpness
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Joint swelling

GASTROINTESTINAL

- ☐ Coughing/choking/gagging when eating
- ☐ Frequent vomiting
- ☐ Constipation
- ☐ Frequent heartburn/stomachaches
- ☐ Frequent diarrhea/loose stools

PSYCHIATRIC

- ☐ Mood swings
- ☐ Nervousness
- ☐ Sleep disturbances
- ☐ Depression
- ☐ Temper outbursts

CARDIOVASCULAR

- ☐ Problems with heart
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Blue spells
- ☐ Swelling in hands/feet
- ☐ Irregular heartbeat

OTHER SYMTPOMS

- ☐ Heat or cold intolerance
- ☐ Excessive/night sweats
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Frequent/excessive urination
- ☐ Anemia
- ☐ Easy bruising/bleeding
- ☐ Seasonal allergies/hayfever
- ☐ Food allergies
- ☐ Head congestion
- ☐ Nosebleeds
- ☐ Weak cry/ voice
- ☐ Loss of taste/smell
- ☐ Frequent ear infections
- ☐ _____
  _____

SKIN

- ☐ Eczema
- ☐ Rashes
- ☐ Itching or dryness
- ☐ Birthmarks
- ☐ Areas with abnormal pigment

Known medication allergies: _____

Doctor's Signature: _____