

Patient's Name _____ Date of Birth _____

Review of Systems Questionnaire

To each of the following questions check yes if your child is currently having or has had problems with the symptom mentioned in the last three months.

General:	Weight Loss	Yes/No	Cough	Yes/No	Nipple Swelling	Yes/No
	Weight Gain	Yes/No	Rapid Breathing	Yes/No	Nipple Discharge	Yes/No
	Appetite Loss	Yes/No	Chest Pain	Yes/No	Muscles & Bones:	
Skin:	Rashes	Yes/No	Wheezing	Yes/No	Muscle Weakness	Yes/No
	Change in Moles	Yes/No	Heart: Rapid Heart Beat	Yes/No	Muscle Pain	Yes/No
	Sunburn	Yes/No	Irregular Beat	Yes/No	Joint Pain/Swelling	Yes/No
	Easy Bruising	Yes/No	Fainting/Dizziness	Yes/No	Red Joint/Extremity	Yes/No
	Itching	Yes/No	Gastrointestinal:		Deformed Extremity	Yes/No
	Hair Loss	Yes/No	Vomiting	Yes/No	Swollen Extremity	Yes/No
	Change in Hair	Yes/No	Diarrhea	Yes/No	Back Pain	Yes/No
Lymph:	Enlarged/Painful Glands	Yes/No	Constipation	Yes/No	Nervous System:	
	Eyes: Crossed Eyes	Yes/No	Poor Appetite	Yes/No	Headache	Yes/No
	Itchy Eyes	Yes/No	Vomiting Blood	Yes/No	Decreased Alertness	Yes/No
	Redness	Yes/No	Bloody Stools	Yes/No	Loss of Speech	Yes/No
	Blurred Vision	Yes/No	Soiling Pants	Yes/No	Numbness	Yes/No
	Discharge	Yes/No	Stomach Pain	Yes/No	Seizure	Yes/No
Head/Ears/ Nose/Throat:			Urinary Tract:		Room Spinning	Yes/No
	Runny Nose	Yes/No	Increased Urination	Yes/No	Emotional:	
	Stuffy Nose	Yes/No	Decreased Urination	Yes/No	Hallucinations	Yes/No
	Sneezing	Yes/No	Painful Urination	Yes/No	Sadness	Yes/No
	Ear Pulling	Yes/No	Bloody Urine	Yes/No	Anxiety	Yes/No
	Hearing Loss	Yes/No	Bedwetting	Yes/No	Behavior Problems:	
	Drooling	Yes/No	Daytime Wetting	Yes/No	Home	Yes/No
	Sore Throat	Yes/No	Reproductive:		School	Yes/No
Neck:	Stiffness/Pain	Yes/No	Swollen Testicles	Yes/No	Extreme Anger	Yes/No
	Masses	Yes/No	Painful Testicles	Yes/No		
	Swollen Glands	Yes/No	Abnormal Menses	Yes/No		
Respiratory:				Yes/No		