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.

Yes/No

General: Weight Loss ☐☐
Weight Gain ☐☐
Appetite Loss ☐☐

Skin: Rashes ☐☐
Change in Moles ☐☐
Sunburn ☐☐
Easy Bruising ☐☐
Itching ☐☐
Hair loss ☐☐
Change in Hair ☐☐

Lymph: Enlarged/Painful ☐☐
Glands ☐☐

Eyes: Crossed Eyes ☐☐
Itchy Eyes ☐☐
Redness ☐☐
Blurred Vision ☐☐
Discharge ☐☐

Head/Ears/ Nose/Throat:
Runny Nose ☐☐
Stuffy Nose ☐☐
Sneezing ☐☐
Ear Pulling ☐☐
Hearing Loss ☐☐
Drooling ☐☐
Sore Throat ☐☐

Neck: Stiffness/Pain ☐☐
Masses ☐☐
Swollen Glands ☐☐

Respiratory:

Yes/No

Cough ☐☐
Rapid Breathing ☐☐
Chest Pain ☐☐
Wheezing ☐☐

Heart: Rapid Heart Beat ☐☐
Irregular Beat ☐☐
Fainting/Dizziness ☐☐

Gastrointestinal:
Vomiting ☐☐
Diarrhea ☐☐
Constipation ☐☐
Poor Appetite ☐☐
Vomiting Blood ☐☐
Bloody Stools ☐☐
Soiling Pants ☐☐
Stomach Pain ☐☐

Urinary Tract:
Increased Urination ☐☐
Decreased Urination ☐☐
Painful Urination ☐☐
Bloody Urine ☐☐
Bedwetting ☐☐
Daytime Wetting ☐☐

Reproductive:
Swollen Testicles ☐☐
Painful Testicles ☐☐
Abnormal Menses ☐☐

Yes/No

Nipple Swelling ☐☐
Nipple Discharge ☐☐

Muscles & Bones:
Muscle Weakness ☐☐
Muscle Pain ☐☐
Joint Pain/Swelling ☐☐
Red Joint/Extremity ☐☐
Deformed Extremity ☐☐
Swollen Extremity ☐☐
Back Pain ☐☐

Nervous System:
Headache ☐☐
Decreased Alertness ☐☐
Loss of Speech ☐☐
Numbness ☐☐
Seizure ☐☐
Room Spinning ☐☐

Emotional:
Hallucinations ☐☐
Sadness ☐☐
Anxiety ☐☐

Behavior Problems:
Home ☐☐
School ☐☐
Extreme Anger ☐☐