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Review of Systems

__ Initial Visit __Follow-up Visit

Patient's Full Name: _____ **Date of Birth**: _____

Date of Visit: _____ **Appointment Time**: _____

Parent/Patient/Guardian Printed Name: _____

Parent/Patient/Guardian Signature: _____

Reason for visit: ___ADHD/ADD ___Headaches ___Seizures ___Autism/Development concerns
__Other:_____

CURRENT REVIEW OF SYSTEMS:

For insurance coverage purposes, please circle all that *currently* apply.

CONSTITUTIONAL: weight loss, fever, chills, weakness, fatigue

EYES: visual loss, blurred vision, double vision, yellow sclera (outer part of eye).

EARS, NOSE, THROAT: hearing loss, sneezing, congestion, runny nose, sore throat

SKIN: rash, itching

CARDIOVASCULAR: chest pain, chest pressure, chest discomfort, palpitations, edema

RESPIRATORY: shortness of breath, cough, sputum

GASTROINTESTINAL: anorexia, nausea, vomiting or diarrhea, abdominal pain.

GENITOURINARY: burning on urination, blood in urine

NEUROLOGICAL: seizures, headache, dizziness, syncope, paralysis, ataxia, numbness or tingling in the extremities, problems with bowel, problems with bladder control

MUSCULOSKELETAL: muscle pain, back pain, joint pain, stiffness

HEMATOLOGIC: anemia, bleeding, bruising

LYMPHATICS: enlarged nodes, splenectomy

PSYCHIATRIC: depression, anxiety, suicidal or homicidal thoughts, behavioral issues

ENDOCRINOLOGIC: sweating, cold intolerance, heat intolerance, frequent urination, increased thirst

Medications:_____

_____

Allergies: medication allergies Yes or No. If yes, then please list _____

Other allergies:_____

Any updates to medical history since your last visit?:

_____

_____