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Pediatric Neurology

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Review of Systems

Initial Visit

Follow-up Visit

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

Appointment Date: _____ **Appointment Time:** _____

Parent/Patient/Guardian Printed Name: _____

Parent/Patient/Guardian Signature: _____

Reason for Visit: ADHD/ADD Headaches Seizures
Autism/Developmental concerns

Other (*please specify*):

CURRENT REVIEW OF SYSTEMS

For insurance coverage purposes, please mark all that currently apply. None of these

CONSTITUTIONAL: weight loss fever chills weakness fatigue

EYES: visual loss blurred vision double vision yellow sclera (outer eye)

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

SKIN: rash itching

CARDIOVASCULAR: chest pain chest pressure edema chest discomfort
 palpitations

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

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Review of Systems

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 or heat intolerance frequent urination
increased thirst

Medications? No Yes (*please list*): _____

Allergies? No Yes (*please list*): _____

Any updates to medical history since your last visit? No Yes (*please list*): _____
