PEDIATRIC/TEEN PATIENT INTAKE- REVIEW OF SYSTEMS

Thank you for taking the time to answer these questions.

Most insurance companies require this information to be updated at ***every*** *visit*.

PATIENT NAME:________________________

DATE:__________________________________

Please check any symptoms which you (today's patient) are currently experiencing

Constitutional

- [ ] Fatigue
- [ ] Weight loss
- [ ] Weight gain

Head, Ears, Nose,Throat

- [ ] Headache
- [ ] Sore throat
- [ ] Decreased hearing

Breast

- [ ] Breast lumps
- [ ] Breast tenderness
- [ ] Nipple discharge

Cardiovascular

- [ ] Chest pain
- [ ] Irregular heartbeat

Respiratory

- [ ] Cough
- [ ] Wheezing
- [ ] Shortness of breath

Gastrointestinal

- [ ] Nausea/vomiting
- [ ] Diarrhea
- [ ] Constipation
- [ ] Abdominal pain

Skin/Hair

- [ ] Rash
- [ ] Skin lesions

Neurologic

- [ ] Seizures
- [ ] Tingling
- [ ] Numbness

Musculoskeletal

- [ ] Joint pain
- [ ] Joint swelling

Endocrine

- [ ] Hair loss
- [ ] Temperature intolerance
- [ ] Abnormal hair growth

When was the patient's last menstrual period? (if applicable)

____

Has the patient had any serious illnesses, operations or hospitalizations since her last visit?

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Is there any additional information about your family history that we should know?

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Have any habits (smoking, drinking etc.) or occupation changed since your last visit?

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Please list all current medications and doses including herbals and vitamins

_______________________ _________________________ _____________________

_______________________ _________________________ _____________________

Please list any current allergies

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Please briefly describe the reason for today's visit

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