

Today's Date _____

Child's Name _____ DOB _____ Sex _____

Family Background

Mother's Name _____ DOB _____ Occupation _____

Medical problems _____

Father's Name _____ DOB _____ Occupation _____

Medical problems _____

	Names of other children	Age	Sex	Medical problems
1.				
2.				
3.				
4.				
5.				
6.				

Child's Medical History

Does or did your child have any delays in development? Were there any treatments for this?

Please Note the type of delay and treatments for it below.

Does your child have any allergies to medications or food, seasonal allergies, asthma, or eczema? Please describe below.

Has your child ever been hospitalized? If yes, please give details below of each admission as best you can (why they were admitted, how old they were, which hospital, how long they stayed).

Has your child had any surgery" if yes, please give details below (what surgery, how old they were, which hospital).

Has your child had any broken bones, or concussions? If yes, please give details below.

Does your child take any medications on a regular basis? If yes, please give details below.

Does your child seem to see and hear well?

REVIEW OF SYSTEMS- Teen Brief

Name: _____ DOB: _____

****Please check only the symptoms your child currently has****

General

- Abnormal weight gain
- Abnormal weight loss
- Fatigue/weakness
- Frequent fevers
- Trouble sleeping

Skin

- Rash
- Lumps
- Itching
- Excessively dry skin
- Sun sensitivity
- Hair and nail changes

Head/Neck

- Frequent headaches
- Head injury
- Neck pain
- Neck stiffness
- Swollen glands
- Lumps

Eyes

- Eye redness
- Eye pain
- Eye discharge
- Blurry or double vision
- Vision loss
- Wear glasses/contacts

Ears

- Decreased hearing
- Frequent ear pain
- Ear drainage

Nose

- Constant nasal congestion
- Nasal discharge/drainage
- Frequent nosebleeds
- Sinus pain

Throat/Mouth

- Bleeding gums
- Dry mouth
- Constantly sore throat
- Hoarse voice
- Thrush
- Non-healing sores

Breasts

- Breast lumps
- Pain
- Nipple discharge

Respiratory

- Frequent cough
- Coughing up phlegm
- Shortness of breath
- Wheezing
- Pain with breathing

Cardiovascular

- Chest pain or discomfort
- Chest tightness
- Palpitations (rapid heartbeat)
- Shortness of breath with exertion

Gastrointestinal

- Difficulty swallowing
- Heartburn
- Nausea
- Frequent vomiting
- Constipation
- Diarrhea
- Blood in stool

Urinary

- Frequent urination
- Urgency to urinate
- Wetting accidents
- Burning/painful urination
- Lower back pain
- Dark or bloody urine
- Decreased urine

Female

- Heavy bleeding during periods
- Irregular periods
- Missed periods
- Heavy cramping before or during periods
- Bleeding between periods
- Vaginal discharge/itching

Male

- Rash or blisters on penis
- Discharge from penis
- Bulge or lump in groin
- Lump on the testicle
- Scrotal pain
- Scrotal swelling
- Undescended testicle

Musculoskeletal

- Painful joints
- Frequent muscle aches
- Swollen joints
- Joint redness
- Back pain
- Trauma
- Difficulties walking

Neurologic

- Dizziness
- Fainting
- Seizures
- Weakness
- Tingling/numbness
- Tremor (shaky hands)
- Tics
- Balance difficulty
- Gait abnormality
- Headache
- Loss of strength

Hematologic

- Easy bruising
- Easy or prolonged bleeding
- Swollen glands

Endocrine

- Cold intolerance
- Heat intolerance
- Excessive sweating
- Frequent urination
- Excessive thirst
- Change in appetite

Psychiatric/Behavioral

- Nervousness/anxiety
- Stress
- Depression
- Behavior difficulties
- Substance abuse
- Suicidal thoughts

Patient name: _____ DOB: _____

Family History

Condition:	Relation to patient (mother, father, sibling, etc):
<input type="checkbox"/> ADHD	_____
<input type="checkbox"/> Allergies or hay fever	_____
<input type="checkbox"/> Anemia	_____
<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Bleeding problems	_____
<input type="checkbox"/> Birth defects/genetic defects	_____
-What kind of defect?	_____
<input type="checkbox"/> Cancer	_____
-What kind of cancer?	_____
<input type="checkbox"/> Blood clotting problems	_____
<input type="checkbox"/> Depression	_____
<input type="checkbox"/> Diabetes- type 1	_____
<input type="checkbox"/> Diabetes- type 2	_____
<input type="checkbox"/> Down syndrome	_____
<input type="checkbox"/> Epilepsy/seizures	_____
<input type="checkbox"/> Food allergies	_____
-What kind of food?	_____
<input type="checkbox"/> Hearing loss	_____
<input type="checkbox"/> Heart attack	_____
<input type="checkbox"/> High blood pressure	_____
<input type="checkbox"/> High cholesterol	_____
<input type="checkbox"/> Hyperthyroidism ("high thyroid")	_____
<input type="checkbox"/> Hypothyroidism ("low thyroid")	_____
<input type="checkbox"/> Infertility	_____
<input type="checkbox"/> Irregular heartbeat	_____
<input type="checkbox"/> Intellectual disability/developmental delay:	_____
<input type="checkbox"/> Kidney trouble (renal disease)	_____
<input type="checkbox"/> Mood disorder or bipolar	_____
<input type="checkbox"/> Neurofibromatosis	_____
<input type="checkbox"/> Obesity	_____
<input type="checkbox"/> Metabolic disease at birth	_____
-What kind of disease?	_____
<input type="checkbox"/> Schizophrenia	_____
<input type="checkbox"/> Smoking	_____
<input type="checkbox"/> Stillbirth	_____
<input type="checkbox"/> SIDS (sudden infant death)	_____
<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Vision loss	_____
<input type="checkbox"/> Violence/domestic abuse	_____
<input type="checkbox"/> Alcohol abuse	_____
<input type="checkbox"/> Drug abuse	_____