**REVIEW OF SYSTEM**

 **FILL OUT THESE FORMS BEFORE YOUR APPOINTMENT**

**Please check any problems (boxes) listed below which have significantly affected your child.**

**Constitutional**

□ Recent weight gain\_\_\_\_\_(amount)

Recent weight loss\_\_\_\_\_(amount)

□ Fatigue

□ Weakness

□ Fever

**Eyes**

□ Pain

□ Redness

□ Loss of vision

□ Double or blurred vision

□ Dryness

□ Feels like something in eye

□ Itching eyes

**Ears–Nose–Mouth–Throat**

□ Loss of hearing

□ Nosebleeds

□ Loss of smell

□ Dryness in nose

□ Runny nose

□ Bleeding gums

□ Sores in mouth

□ Dryness of mouth

□ Hoarseness

□ Difficulty in swallowing

**Cardiovascular**

□ Pain in chest

□ High blood pressure

**Respiratory**

□ Shortness of breath

□ Cough

□ Coughing of blood

□ Wheezing (asthma)

**Gastrointestinal**

□ Nausea

□ Vomiting

□ Stomach pain

□ Constipation

□ Diarrhea

□ Blood in stools

□ Heartburn

**Genitourinary**

□ Pain or burning on urination

□ Blood in urine

□ Sores on private parts

*For Women Only:*

Periods regular? □ Yes □ No

Date of last period?

**Integumentary (skin)**

□ Easy bruising

□ Rash\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Sun sensitive (sun allergy)

□ Tightness

□ Hair loss

□ Color changes of handsor feet in the cold

**Neurological System**

□ Headaches

□ Dizziness

□ Fainting

□ Numbness or tingling of hands

□ Numbness or tingling of feet

□Memory loss

□ Night sweats

**Allergic/Immunologic**

□ Frequent sneezing

□ Hives

**Hematologic/Lymphatic**

□ Swollen glands

**Psychiatric**

□ Anxiety

□ Easily losing temper

□ Depression

□ Difficulty falling asleep

□ Difficulty staying asleep

**Endocrine**

□ Excessive thirst

□ Excessive urination

**Musculoskeletal**

□ Morning stiffness, lasting how long?

\_\_\_\_\_\_\_\_\_Minutes\_\_\_\_\_\_\_\_Hours

□ Muscle weakness

□ Muscle tenderness

□ Back pain

□ Joint pain

□ Joint swelling

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  | **PATIENT HISTORY** |  |  |  **Apply Patient Label** |
|  |  |  |  |  | **REVIEW OF SYSTEMS** |  |  |
|  |  |  |  |  |  |  |  |  |
|  | **PAST MEDICAL HISTORY** |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  | Does your child have or ever had? Check if “yes” |  |  |  |  |  |  |
|  | Cancer | Heart problems |  |  Anxiety |  |  |
|  | Fibromyalgia | Diabetes |  |  |  Tuberculosis |
|  | Stomach ulcers | Epilepsy/Seizures |  |  Rheumatic Fever |
|  | Kidney disease | Valley Fever |  |  Psoriasis |  |  |
|  | Crohn’s disease | Immunodeficiency |  |  High Blood Pressure |
|  | Ulcerative Colitis | Depression |  |  Asthma |  |  |
|  | Other significant illness (please list) |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  | **SOCIAL HISTORY** |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Who lives at home with patient? |
|  | Patient use: tobacco? | Yes | No |  | Yes | No |
|  | Do you use drugs for reasons that are not medical? | Yes | No |  |  |  |  |
|  | If yes, please list | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Do you exercise regularly? | Yes | No Hours per week: \_\_\_\_\_\_\_\_\_\_\_ |
|  | Type of exercise: |  |  |  |  |  |  |  |  |



Grade in school \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grades \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Of days absent from school due to rheumatic disease? \_\_\_\_\_\_\_\_\_\_\_

**TRAVE**L in last year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PETS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **IMMUNIZATIONS:** |  |  |
| * Up-to-date
 |  |
| * Date of last immunization
 |  |  |  |
| **Previous Operations** |  |  |  |
|  |  |  |
| ***Type & Year*** |  |  | ***Type & Year*** |
| 1. |  |  | 3. |
| 2. |  |  | 4. |

|  |  |  |
| --- | --- | --- |
| **FAMILY HISTORY:** | **IF LIVING** | **IF DECEASED** |
|  |  |
| Age | Medical Problems |  Age at Death |  Cause |

Father

Mother

Number of sisters Number of brothers Number deceased

Medical problems of brothers and sisters:

|  |  |  |  |
| --- | --- | --- | --- |
|  | **PATIENT HISTORY:** |  | **Apply Patient Label** |
|  |  **REVIEW OF SYSTEMS** |  |
|  |  |  |  |
| **FAMILY HISTORY:** |  |  |  |  |  |
|  |  |  |  |
| Do you know of any blood relative who has or had: (check and give relationship) |  |  |
| □Psoriasis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | □Immune Deficiency Syndrome \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □Lupus\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □Heart Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □Fever Syndrome\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □High Blood Pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □Ankylosing Spondylitis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □Rheumatoid arthritis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □Thyroid Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Childhood arthritis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □Epilepsy/Seizures \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □Gout \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □Asthma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Rheumatic fever \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □Diabetes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □Crohn’s Disease/Ulcerative Colitis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Fibromyalgia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **Signature of Patient/Legally Authorized Representative** | **Date** |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Printed Name/Patient or Legally Authorized Representative** | **Relationship to Patient** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Practitioner Signature** | **Date** | **Time** |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Practitioner Printed Name**