**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**