

ROS Pediatric Review of Systems for ages Birth to 16

Print CHILD's Name:

Birth Date:

DIRECTIONS: Please answer each question by checking either Y for yes or N for no and filling in the blank. Circle the number by any question you wish to discuss with the doctor, nurse or provider.

GENERAL

- 1 Is your child's activity level normal?
- 2 Is your child's appetite (or weight) normal?
- 3 Is your child's sleep normal?
- 4 Is your child's growth & development normal?
- 5 Is your child's speech and language normal?

YES NO

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RESPIRATORY

- 1 Does your child have problems with coughing?
- 2 Does your child have problems with wheezing?
- 3 Does your child have problems with shortness of breath?

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HEENT

- 1 Does your child have frequent headaches?
- 2 Do your child have problems with vision?
- 3 Do your child have problems with hearing?
- 4 Does your child have itchy/watery eyes or a stuffy nose?

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CARDIOVASCULAR

- 1 Does your child get chest pain?
- 2 Does your child get palpitations or an irregular heartbeat?

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HEMATOPOETIC / ENDOCRINE

- 1 Does your child have easy bruising or bleeding?
- 2 Does your child have difficulty w/ hot or cold environments?
- 3 Does your child have excessive thirst?
- 4 Does your child have excessive urination?

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DERMATOLOGIC

- 1 Does your child have skin rashes?
- 2 Does your child have acne?
- 3 Does your child have concerning moles or lumps?

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NEUROLOGICAL

- 1 Has your child had fainting spells?
- 2 Has your child had serious head injuries?
- 3 Has your child had seizures or epilepsy?

YES NO

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PSYCHOLOGICAL /PSYCHIATRIC

- 1 Is your child frequently uncooperative or defiant?
- 2 Does your child have difficulty getting along with others – children or teachers?
- 3 Does your child seem anxious or depressed?

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GI

- 1 Does your child have problems with diarrhea?
- 2 Does your child have problems with constipation?
- 3 Does your child have abdominal pain?
- 4 Does your child have vomiting?

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GU

- 1 Does your child have good bladder control?
- 2 Does your child have good bowel control?
- 3 Do you have concerns about your child's sexual development?

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BIRTH HISTORY

- 1 Was this a planned pregnancy?
- 2 Was this child born pre-maturely?
- 3 Describe any difficulties:

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SOCIAL HISTORY

- 1 Is your child attending school? Grade? _____
- 2 Is your child exposed to cigarette smoke?
- 3 Are you concerned about your child using tobacco?
- 4 Are you concerned about child using illegal drugs?
- 5 Are you concerned about your child using alcohol?
- 6 Who lives in your child's home? (list relationships)

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LIST ANY HEALTH PROBLEMS OR OTHER CONCERNS:

Patient's Signature:

Date

Providers Initials: