

# Pediatric Review of Systems

Patient's Name:

Date of Birth:

Gender:

Relevant Medical History:

Referring Physician's Name:

## GENERAL

Symptom	Present or Absent?	Additional Notes
Fever	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Chills	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Fatigue	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Weakness	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Fussiness	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Poor Feeding/Change in Appetite	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Sleep Disturbance	<input type="checkbox"/> Present <input type="checkbox"/> Absent	

Sleeping More than Usual	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
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**WEIGHT**

Symptom	Present or Absent?	Additional Notes
Recent Changes	<input type="checkbox"/> Present <input type="checkbox"/> Absent	

**SKIN AND LYMPH**

Symptom	Present or Absent?	Additional Notes
Rashes	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Adenopathy or Swollen Lymph Nodes	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Lumps	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Bruising and Bleeding	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Pigmentation Changes	<input type="checkbox"/> Present <input type="checkbox"/> Absent	

## HEENT

Symptom	Present or Absent?	Additional Notes
Headaches	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Concussions	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Unusual Head Shape	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Strabismus	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Conjunctivitis	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Visual Problems	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Hearing	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Ear Infections	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Draining Ears	<input type="checkbox"/> Present <input type="checkbox"/> Absent	

Cold and Sore Throats	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Tonsilitis	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Mouth Breathing	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Snoring	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Apnea	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Oral Thrush	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Epistaxis	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Caries	<input type="checkbox"/> Present <input type="checkbox"/> Absent	

## CARDIAC

Symptoms	Present or Absent?	Additional Notes
Cyanosis	<input type="checkbox"/> Present <input type="checkbox"/> Absent	

Dyspnea	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Heart Murmurs	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Exercise Intolerance	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Squatting	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Chest Pain	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Palpitations	<input type="checkbox"/> Present <input type="checkbox"/> Absent	

## RESPIRATORY

Symptoms	Present or Absent?	Additional Notes
Pneumonia	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Bronchiolitis	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Wheezing	<input type="checkbox"/> Present <input type="checkbox"/> Absent	

Chronic Cough	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Sputum	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Hemoptysis	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
TB exposure	<input type="checkbox"/> Present <input type="checkbox"/> Absent	

## GI

Symptoms	Present or Absent?	Additional Notes
Change in stool color and character	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Diarrhea	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Constipation	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Vomiting	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Vomiting Blood	<input type="checkbox"/> Present <input type="checkbox"/> Absent	

Jaundice	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Abdominal Pains	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Colic	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Change in Appetite	<input type="checkbox"/> Present <input type="checkbox"/> Absent	

## GU

Symptoms	Present or Absent?	Additional Notes
Frequency	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Dysuria	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Hematuria	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Discharge	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Abdominal Pains	<input type="checkbox"/> Present <input type="checkbox"/> Absent	

Quality of Urinary Stream	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Polyuria	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Previous Infections	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Facial Edema	<input type="checkbox"/> Present <input type="checkbox"/> Absent	

## MUSCULOSKELETAL

Symptoms	Present or Absent?	Additional Notes
Joint Pains or Swelling	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Fevers	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Scoliosis	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Muscle Aches or Weakness	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Injuries	<input type="checkbox"/> Present <input type="checkbox"/> Absent	



Gait Changes	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
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## NEURO

Symptoms	Present or Absent?	Additional Notes
Seizures	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Weakness	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Headaches	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Numbness	<input type="checkbox"/> Present <input type="checkbox"/> Absent	

## PUBERTAL

Symptoms	Present or Absent?	Additional Notes
Secondary Sexual Characteristics	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Menses and Menstrual Problems	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Pregnancies	<input type="checkbox"/> Present <input type="checkbox"/> Absent	

Sexual Activity	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
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**ALLERGY**

Symptoms	Present or Absent?	Additional Notes
Urticaria	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Hay Fever	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Allergic Rhinitis	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Asthma	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Eczema	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Drug Reactions	<input type="checkbox"/> Present <input type="checkbox"/> Absent	

**PSYCHIATRIC**

Symptoms	Present or Absent?	Additional Notes
Difficulty Sleeping	<input type="checkbox"/> Present <input type="checkbox"/> Absent	

Behavioral Changes	<input type="checkbox"/> Present <input type="checkbox"/> Absent	
Hyperactivity	<input type="checkbox"/> Present <input type="checkbox"/> Absent	

**Summary or Additional Notes:**