

Date ___/___/___

Patient Name:

Account No.

DOB:

Pediatric Initial Visit (p. 2): Please provide the following medical information to the best of your ability:

Review of Systems:								
1) Please check the "Yes" or "No" box to indicate whether you presently have any of the following symptoms:								
2) For any "yes" responses, please check the "current" box if this symptom relates to the reason for your visit today								
		Yes	No	Current		Yes	No	Current
GENERAL	chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	weight loss or gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	daytime sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ALLERGY	environmental allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sneezing fits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	post-nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	food allergies			
NEURO	headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	passing out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness, tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EYES	eye pain / pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	vision changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	watery or itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
ENT	ear pain or itch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ear drainage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ear noises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	recurrent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	swelling neck or face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	dizziness, vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	lightheadedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	mouth breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus pressure or pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	recurrent "sinus infec"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	discolored nasal dischg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	recurrent throat infec	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	snoring with pauses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	throat pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	throat clearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	throat dryness/itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RESPIR.	cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	coughing blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CARDIAC	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	wake short of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GI	difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	bowel irregularity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GU	frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	painful urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	prostate problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEME/LYM	swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sweating at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDO	feel warmer than others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feel cooler than others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	increased thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	increased urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MSK	joint aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	muscle aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SKIN	rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	skin or hair changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PSYCH	depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anxiety or panic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<u>PLEASE STOP HERE</u>	<input type="checkbox"/> See attached dictation		
Reviewed by:								