HEARTLAND COMMUNITY HEALTH CENTER

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Pediatric Review of Systems (10 years and under)

Patient Name: _____ DOB: _____
Today's Date: _____ Preferred Pharmacy: _____
Date of last dental exam: _____

Please circle anything that you have experienced in the <u>past two weeks</u>:

WEIGHT - recent changes

ORAL HEALTH – dry mouth, mouth pain, tooth pain, swelling

SKIN & LYMPH - rashes, swollen lymph nodes, lumps, bruising and bleeding, pigmentation changes

HEENT - headaches, concussions, unusual head shape, eye redness or discharge, visual problems, hearing, ear infections, draining ears, cold and sore throats, mouth breathing, snoring, apnea, white patches on tongue, nosebleeds, cavities

CARDIAC – fatigue, shortness of air, turning blue, heart murmurs, exercise intolerance, squatting, chest pains, palpitations

RESPIRATORY - wheezing, chronic cough, productive cough, coughing up blood, exposure to TB

GI - stool color and character, diarrhea, constipation, vomiting, vomiting blood, jaundice, abdominal pains, colic, change in appetite

GU - frequency, painful urination, blood in urine, discharge, abdominal pains, previous infections, facial swelling

MUSCULOSKELETAL - joint pains or swelling, fevers, scoliosis, muscle aches or weakness, injuries, gait changes

NEURO – seizures, weakness, headaches, numbness

PUBERTAL - menses and menstrual problems, pregnancy, sexual activity

ALLERGY - hives, hay fever, allergies, asthma, eczema, drug reactions

PSYCHIATRIC – difficulty sleeping, behavioral changes, hyperactivity