Olive Branch Pediatrics

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Review of Systems

Please place a check mark next to any of the following symptoms that apply to the patient's current health.

General:
Fever ________
Fatigue ________
Weight Loss ________

Eyes:
Blurred Vision ________
Eye Pain ________
Glasses ________

Ear/Nose/Throat:
Ear Pain ________
Decreased Hearing ________
Nosebleeds ________
Nasal Congestion ________
Runny Nose ________
Sore Throat ________
Hoarseness ________
Difficulty Swallowing ________

Respiratory:
Cough ________
Wheezing ________
Shortness of Breath ________

Cardiovascular:
Heart Murmur ________
Chest Pain ________
Irregular Heart Beat ________
Blood Pressure Problem ________

Gastrointestinal:
Abdominal Pain ________
Nausea ________
Vomiting ________
Diarrhea ________
Constipation ________
Blood in Stool ________
Heartburn ________

Genitourinary:
Pain with Urination ________
Blood in Urine ________
Frequent Urination ________
Bedwetting ________

Endocrine:
Hair Loss ________
Cold/Heat Intolerance ________
Abnormal Period ________

Skin:
Rash ________
Acne ________

Hematology:
Easy Bleeding ________
Easy Bruising ________
Anemia ________

Musculoskeletal:
Bone Pain ________
Back Pain ________
Swollen Joint ________
Muscle Pain ________

Neurological:
Headache ________
Seizures ________
Dizziness ________
Numbness ________

Allergic:
Food Allergy ________
Medication Allergy ________

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Tuberculosis Questionnaire

Please check the box below that matches your answer:

	Yes	No	Don't Know
1. Has your child ever been tested for TB? If yes, when? ___________________________________			
2. Have your ever been told that your child had a positive tuberculin skin or other tuberculosis test? If yes, when? ___________________________________			
3. Has your child been around anyone who has had an unexplained prolonged fever, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood?			
4. Has your child been around anyone sick with tuberculosis?			
5. Was your child born in another part of the world such as Mexico, Latin America, the Caribbean, Africa, Eastern Europe, or Asia?			
6. Has your child been to Mexico, Latin America, the Caribbean, Africa, Eastern Europe, or Asia for more than three weeks?			
7. Has your child been around anyone who uses needles for illicit drug use, has AIDS or HIV, was recently in jail or prison, is homeless, or has just come to the US from a different country?			

Patient Health Questionnaire (PHQ-9)

Patient name: ________________________________ Date: __________________

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
a. Little interest or pleasure in doing things.	❐	❐	❐	❐
b. Feeling down, depressed, or hopeless.	❐	❐	❐	❐
c. Trouble falling/staying asleep, sleeping too much.	❐	❐	❐	❐
d. Feeling tired or having little energy.	❐	❐	❐	❐
e. Poor appetite or overeating.	❐	❐	❐	❐
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.	❐	❐	❐	❐
g. Trouble concentrating on things, such as reading the newspaper or watching TV.	❐	❐	❐	❐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual.	❐	❐	❐	❐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	❐	❐	❐	❐

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

❐ Not difficult at all ❐ Somewhat difficult ❐ Very difficult ❐ Extremely difficult

TOTAL SCORE ________________

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