



## 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 \_\_\_\_\_



## 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?<br>If yes, when? _____  |     |    |            |
| 2. Have you ever been told that your child had a positive tuberculin skin<br>or other tuberculosis test?<br>If yes, when? _____  |     |    |            |
| 3. Has your child been around anyone who has had an unexplained<br>prolonged fever, unexplained weight loss, a bad cough (lasting over two<br>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<br>America, the Caribbean, Africa, Eastern Europe, or Asia?  |     |    |            |
| 6. Has your child been to Mexico, Latin America, the Caribbean, Africa,<br>Eastern Europe, or Asia for more than three weeks?  |     |    |            |
| 7. Has your child been around anyone who uses needles for illicit drug<br>use, has AIDS or HIV, was recently in jail or prison, is homeless, or has just<br>come to the US from a different country? |     |    |            |