Patient's Name: _____ **Date of Birth:** _____

REVIEW OF SYSTEMS

(Please indicate any of the following problems your child has experienced on a **regular basis**)

CONSTITUTIONAL SYMPTOMS
- Good general health lately..... Yes No
- Excessive weight gain/loss..... Yes No

EYES
- Eye disease or injury..... Yes No
- Wears glasses/contact lenses..... Yes No

EARS/NOSE/THROAT
- Hearing loss or ringing..... Yes No
- Earaches/infections/drainage..... Yes No
- Chronic sinus infections..... Yes No
- Nose bleeds..... Yes No
- Strep/throat infections..... Yes No

CARDIOVASCULAR
- Heart defect/murmur..... Yes No
- Palpitations/chest pain..... Yes No
- High/low blood pressure..... Yes No

RESPIRATORY
- Chronic frequent coughs..... Yes No
- Asthma /wheezing..... Yes No

GENITOURINARY
- Frequent/painful urination..... Yes No
- Blood in urine..... Yes No
- Bed wetting..... Yes No
- Kidney reflux..... Yes No
- Undescended/painful testicles... Yes No
- Irregular/painful periods..... Yes No

LEAD EXPOSURE ASSESSMENT

~Does your child .....
- ~Live in or regularly visit a house with peeling or chipping paint built before 1960? This could include a daycare, preschool, home of a babysitter or a relative, etc..... Yes No
- ~Live in or regularly visit a house built before 1960 with recent, ongoing, or planned renovation or remodeling?..... Yes No
- ~Have a brother or sister, housemate, or playmate being followed up or treated for lead poisoning? .. Yes No
- ~Live with an adult whose job or hobby involves exposure to lead? ..... Yes No
- ~Live near an active lead smelter, battery recycling plant, or other industry likely to release lead? ..... Yes No

GASTROINTESTINAL
- Frequent vomiting..... Yes No
- Irregular bowel movements..... Yes No
- Rectal bleeding/bloody stools..... Yes No

MUSCULOSKELETAL/SKIN
- Joint swelling/pain..... Yes No
- Acne..... Yes No
- Changes in skin/hair/nails..... Yes No

NEUROLOGICAL/PSYCHIATRIC
- Frequent/recurrent headaches..... Yes No
- Convulsions/seizures..... Yes No
- Head injury..... Yes No

ENDOCRINE
- Thyroid disease..... Yes No
- Diabetes..... Yes No
- Excessive thirst or urination..... Yes No

HEMATOLOGIC/LYMPHATIC
- Bleeding disorder..... Yes No
- Anemia..... Yes No
- Blood transfusions..... Yes No
- Enlarged glands..... Yes No

ALLERGIC/IMMUNOLOGIC
- Frequent/recurrent congestion.... Yes No
- Frequent/recurrent hives..... Yes No

PLEASE LIST KNOWN ALLERGENS :

_____
_____
_____
_____
_____

PLEASE SHARE ANY INFORMATION YOU FEEL WE NEED TO KNOW TO BETTER CARE FOR YOUR CHILD:

_____
_____
_____
_____
_____
_____
_____
_____

_____ PARENT'S SIGNATURE

_____ MD/DO/ARNP SIGNATURE

_____ DATE

NOTES BY PROVIDER: