

Review of Symptoms: (Please circle any symptoms your child has exhibited over the **past week**)

Constitutional	Weight loss/gain (circle which)	Fever	Fatigue	<input type="checkbox"/> No current concerns Other:
Ophthalmologic	Visual changes	Eye pain	Blurred vision	<input type="checkbox"/> No current concerns Other:
Ears, Nose, Mouth, Throat	Sore throat	Ear infection	Hearing difficulties	<input type="checkbox"/> No current concerns Other:
Cardiovascular	Heart racing	Heart skipping beats	Chest pain	<input type="checkbox"/> No current concerns Other:
Respiratory	Wheezing	Shortness of breath	Cough	<input type="checkbox"/> No current concerns Other:
Gastrointestinal	Nausea/ vomiting	Constipation	Diarrhea	<input type="checkbox"/> No current concerns Other:
Genitourinary	Bedwetting	Pain urinating	Urinary tract infection	<input type="checkbox"/> No current concerns Other:
Musculoskeletal	Muscle pain	Joint pain	Joint swelling	<input type="checkbox"/> No current concerns Other:
Integumentary/ Skin	Eczema	Rash	Itchy skin	<input type="checkbox"/> No current concerns Other:
Neurological	Headache	Feeling faint	Tics	<input type="checkbox"/> No current concerns Other:
Psychiatric	Sadness	Anxiety	Mood swings	<input type="checkbox"/> No current concerns Other:
Endocrine	Excessive thirst	Excessive urination	Poor physical growth	<input type="checkbox"/> No current concerns Other:
Hematologic/ Lymphatic	Lymph node swelling	Easy bleeding	Easy bruising	<input type="checkbox"/> No current concerns Other:
Allergic/ Immunologic	Itchy eyes	Sneezing	Runny nose	<input type="checkbox"/> No current concerns Other:

The information above is complete and accurate to the best of my knowledge.

Parent/ Guardian Signature

Relationship

Date

The information above has been reviewed and formally discussed in depth with the family.

Provider Signature

Date