

Review of Systems for Annual Well Visit

Name of patient _____ DOB _____

Today's Date _____

This Questionnaire has been filled out by _____

Relationship to Patient _____

PLEASE CIRCLE ANY OF THE FOLLOWING THAT ARE OF CONCERN TO YOU

1. General: poor appetite excessive appetite excessive thirst overweight
underweight difficulty sleeping excessive sleeping confusion
fever loss of memory no energy excessive energy
behavior problems
2. Skin: rash acne unexplained lump easy bruising dandruff itching
birth marks
3. Eyes: eye pain blurred vision crossed eyes seen by eye doctor
4. Ear/Nose/Throat: earaches hearing problem loud snoring
concerns about teeth congestion/sneezing/itchy eyes
5. Respiratory: hoarseness cough wheezing difficulty breathing
exercise intolerance
6. Cardiovascular: chest pain heart murmur high blood pressure blue spells
fainting spells
7. Gastrointestinal: abdominal pain nausea vomiting diarrhea pain after eating
hard or painful stools blood in stool stool in underwear
8. Urinary: painful urination frequent urination abnormal urine stream
daytime wetting bed wetting urine color other than yellow
9. Skeletal: bone/muscle/joint pain weakness back pain swollen joints
broken bones
10. Neuromuscular: headache migraine numbness loss of coordination/balance
dizziness unexplained movements or jerks seizure
staring spells concussion delayed development
11. If your child is a girl and she has started her menstrual periods, complete the following:
When did she begin? Month _____ Year _____ When was her last period? _____
Circle any that apply: painful/irregular periods excessive bleeding other