

# ENT Partners of Texas

**Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Review of Systems-Pediatric Male/Female

Circle Response

Yes No

### Constitutional

Y N fatigue  
Y N obesity  
Y N unexplained fevers  
Y N weight change

### Eyes

Y N apparent vision problems  
Y N eye drainage

### Ears/Nose/Throat

Y N apparent hearing problems  
Y N ear pain  
Y N ear drainage  
Y N mouth breathing  
Y N nasal congestion  
Y N nosebleeds  
Y N snoring  
Y N hoarseness  
Y N sore throat (persistent)

### Cardiovascular

Y N chest pain  
Y N poor exercise tolerance

### Respiratory

Y N chronic cough  
Y N shortness of breath  
Y N exposure to tobacco smoke

### Gastrointestinal

Y N constipation  
Y N daily multivitamin  
Y N diarrhea  
Y N nausea  
Y N vomiting

### Genitourinary

Y N diaper rash  
Y N toilet training problem

### Musculoskeletal

Y N limb pain  
Y N joint pain  
Y N joint swelling  
Y N weakness

### Integumentary

Y N eczema  
Y N itching  
Y N rashes

### Neurological

Y N dizziness  
Y N fainting  
Y N headaches  
Y N symptoms of ADD/ADHD

### Hematologic/Lymphatic

Y N excess bleeding  
Y N excess bruising  
Y N swollen lymph glands

### Endocrine

Y N frequent urination

### Allergic/Immunologic

Y N seasonal allergies/"hayfever"  
Y N perennial allergies  
Y N frequent URI type illnesses

### Psychiatric

Y N depression  
Y N emotional problems  
Y N nightmares (frequent)  
Y N school problems  
Y N sleep disturbance  
Y N tobacco use

\_\_\_\_\_  
Signature of person completing form

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to patient