Name_____ Date ___/___/___

THIS SECTION TO BE COMPLETED BY PARENT

Review of Systems

Are you concerned about your child's (circle concerns)…	YES	NO
1. eating habits, weight loss/gain, ↓ energy, sleep habits	☐	☐
2. redness, excessive tearing or discharge from eyes	☐	☐
3. recurrent ear, sinus or throat infections; nosebleeds	☐	☐
4. chest pain, shortness of breath, or irregular heart beat	☐	☐
5. frequent colds, cough, wheezing, recurrent bronchitis	☐	☐
6. abdominal pain, vomiting, diarrhea, constipation	☐	☐
7. kidney or bladder problems, infections, blood in urine	☐	☐
8. joint pain, stiffness, swelling; muscle pain, weakness	☐	☐
9. birthmarks, skin rashes, itching, nail or hair problems	☐	☐
10. recurrent headaches, dizziness, tics, weakness, seizures	☐	☐
11. mood changes, anger, nervousness, depression	☐	☐
12. excessive thirst or hunger, ↑ urination, weight loss	☐	☐
13. paleness, anemia, easy bruising, swollen glands	☐	☐
14. milk, food or drug allergies, recurrent infections	☐	☐

Personal/Social History

Do you have any concerns about your child's…	YES	NO
a. overall progress in school	☐	☐
b happiness at school, self esteem, level of self confidence	☐	☐
c. ability to sit still, listen or participate in school activities	☐	☐
d. attendance at school	☐	☐
e. willingness to follow the rules at school	☐	☐
f. ability to get along with classmates and teachers	☐	☐
g. overall physical well being	☐	☐
h. poor eating habits, excessive or improper snacks	☐	☐
i. poor sleeping habits, nightmares, sleep walking or talking	☐	☐
j. lack of energy or stamina	☐	☐
k. level of maturity or independence	☐	☐
l. lack of personal hygiene, hand washing, brushing teeth, e.t.c.	☐	☐
m. Do you have any social concerns: (lack of friends, bullying, negative peer influence, withdrawal from family)?	☐	☐
n. Do you have any behavioral concerns: (acting out, temper outbursts, aggression, violence)?	☐	☐
o. Do you have any emotional concerns: (mood changes, anxiety, depression)?	☐	☐
p. Do you have any concerns about his development?	☐	☐
q. Does your child exercise on a regular basis?	☐	☐
r. Has your child seen a dentist in the past year?	☐	☐
s. Does your child have any body piercing or tattoos?	☐	☐
t. Does your child use a helmet for skating or biking?	☐	☐
u. Does your child use a safety belt when riding in a car?	☐	☐
v. Do you counsel your child about avoiding the use of alcohol, tobacco, drugs and inhalants?	☐	☐
w. Does anyone have a gun in the home?	☐	☐
Do you have any concerns you wish to discuss?	☐	☐

_____

_____

_____

_____ _____

Parent's Signature Date

Parent's section reviewed by_____

History

☐ Previous concerns, consults and procedures reviewed

(Interval: ☐ No Change) Concerns _____

Current Medications _____

Drug Allergies ☐ Yes ☐ No _____

Past / Social / Family History (Interval: ☐ No Change)

Provider Comments

Anticipatory Guidance

General	*Nutrition*	*Injury Prevention*
☐ Growth /Dev.	☐ Nutritious diet	☐ Seat belt
☐ Immunizations	☐ Limit snacks	☐ Bicycle helmets
☐ School	☐ Meals with family	☐ Playground safety
☐ Exercise	☐ Pleasant mealtimes	☐ Swimming pools
☐ Limit television	☐ Fluoride/Fl water	☐ Sun exposure
☐ Dental care		☐ First aid
☐ Drugs, alcohol, tobacco		☐ Gun safety
☐ Ed. Handouts		