Name_____ Date ___/___/___

THIS SECTION TO BE COMPLETED BY PATIENT

Review of Systems

Are you concerned about (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. stress, anxiety, sadness, depression, suicide thoughts	☐	☐
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…	YES	NO
a. Do you have any health concerns?	☐	☐
b. Do you have any school / work concerns *(circle)* poor grades, lack of motivation, loss of interest, difficulty concentrating, completing assignments, behavior?	☐	☐
c. Do you have any concerns about body image, self esteem?	☐	☐
d. Do you exercise regularly?	☐	☐
e. Do you have any body piercing or tattoos?	☐	☐
f. In the past year have you tried to lose weight by vomiting, taking pills, laxatives or starving yourself?	☐	☐
g. Do you have any concerns about *(circle)* your breasts, menstruation, pelvic pain, vaginal discharge?	☐	☐
Do you have problems with menstruation?	☐	☐
When was your last period? _____		
h. Have you had a pelvic examination?	☐	☐
approx. date _____ Pap test _____		
i. Are you sexually active now?	☐	☐
j. If yes, does your partner always use a condom?	☐	☐
k. Do you have concerns about inappropriate sexual behavior, pain or bleeding with intercourse, birth control, pregnancy, sexually transmitted diseases, exposure to AIDS/HIV?	☐	☐
l. Have you ever been sexually mistreated or abused?	☐	☐
m. Do you have any social concerns: (lack of friends, poor relationship with parents, siblings, friends, teachers)?	☐	☐
n. Do you have any behavioral concerns: (temper outbursts, excessive risk taking, aggression, violence)?	☐	☐
o. Do you smoke cigarettes, use snuff, other?	☐	☐
p. Do you drink alcohol?	☐	☐
If yes, do you drink: ☐ beer ☐ wine ☐ liquor		
☐ daily ☐ weekly ☐ rarely _____# of drinks		
q. Have you been drunk in the past month?	☐	☐
r. Do you ever drive a vehicle when you have been drinking?	☐	☐
s. Do you ever use marijuana, cocaine, inhalants, steroids, other?	☐	☐
t. Do you always use a safety belt when riding in a car?	☐	☐
u. Does anyone have a gun in the home?	☐	☐
Do you have any concerns you wish to discuss?	☐	☐

_____ _____
Patient's Signature Date

Patient'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
- ☐ Growth /Dev.
- ☐ Nutrition
- ☐ School / Work
- ☐ Drugs, alcohol, tobacco
- ☐ Ed. Handouts
- ☐ Exercise
- ☐ Dental care
- ☐ Sex education

Injury Prevention
- ☐ Seat belt
- ☐ Driving safety
- ☐ Risky behavior
- ☐ Sun exposure
- ☐ First aid / CPR
- ☐ Gun safety