me_____ 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, ↓ 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. urinary control, bed wetting, urinary infections	☐	☐
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, sadness, nervous problems	☐	☐
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. progress in reading or math	☐	☐
e. willingness to follow the rules at school	☐	☐
f. ability to get along with classmates and teachers	☐	☐
g. attendance at school	☐	☐
h. overall physical well being	☐	☐
i. poor eating habits, excessive or improper snacks	☐	☐
j. poor sleeping habits, nightmares, sleep walking or talking	☐	☐
k. lack of energy or stamina	☐	☐
l. irritability, temper outbursts, excessive anger	☐	☐
m. lack of personal hygiene, hand washing, brushing teeth, e.t.c.	☐	☐
n. Do you have any other concerns about development or behavior?	☐	☐
o. Do you participate in the activities at school?	☐	☐
p. Are you able to spend individual time with your child daily?	☐	☐
q. Does your child have adult supervision before and after school?	☐	☐
r. Does your child understand and follow safety rules at home?	☐	☐
s. Does your child exercise on a regular basis?	☐	☐
t. Does your child have assigned chores to do?	☐	☐
u. Does your child use a helmet for skating or biking?	☐	☐
v. Does your child use a safety belt and ride in the back seat?	☐	☐
w. Do you counsel your child about avoiding the use of alcohol, tobacco, drugs and inhalants?	☐	☐
x. Does anyone have a gun in the home?	☐	☐
Do you have any concerns you wish to discuss?	☐	☐

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Parent's Signature Date

Parent's section reviewed by_____

8-9 year

History

☐ Previous concerns, consults and procedures reviewed

(Interval: ☐ No Change) Concerns

_____

_____

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Current Medications _____

_____

Drug Allergies ☐ Yes ☐ No _____

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

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Provider Comments

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Anticipatory Guidance

General	*Nutrition*	*Injury Prevention*
☐ Growth / Dev.	☐ Low fat dairy foods	☐ Seat belt
☐ School	☐ Nutritious diet	☐ Bicycle helmets
☐ Exercise	☐ Proper snacks	☐ Playground safety
☐ Limit television	☐ Variable appetite	☐ Parent supervision
☐ Dental care	☐ Pleasant mealtimes	☐ Swimming pools
☐ Drugs, alcohol, tobacco	☐ Fluoride/Fl water	☐ Sun exposure
☐ Ed. Handouts		☐ Gun safety