Pediatric Urology Associates, P.C.

REVIEW OF SYSTEMS

Patient Name:_____ Date of Appt:_____

Date of Birth:_____

*****Please fill in each circle completely. Do not use checkmarks or an "X"****

Genitourinary - female

Blood in urine O Yes O No

Painful urination O Yes O No

Complains of pain in the vagina O Yes O No

Genitourinary - male

Blood in urine O Yes O No

Painful urination O Yes O No

Testicular pain O Yes O No

Psychology

Depression O Yes O No

Sleep disturbances O Yes O No

Anxious/worries O Yes O No

ADD/ADHD O Yes O No

Developmental delay O Yes O No

Obsessive/ compulsive behavior O Yes O No

Musculoskeletal

Special needs i.e. brace, wheelchair O Yes O No

Back pain O Yes O No

General

fever O Yes O No

appetite loss O Yes O No

problems with anesthesia O Yes O No

chills O Yes O No

headaches O Yes O No

ENT/Respiratory

nose bleeds O Yes O No

history of asthma or reactive airway disease O Yes O No

Cardiology

Dizziness	O Yes	O No
Palpitations	O Yes	O No
History of heart murmur	O Yes	O No
Heart surgery	O Yes	O No

Gastroenterology

Blood in stool	O Yes	O No
Constipation	O Yes	O No
Nausea	O Yes	O No
Abdominal pain	O Yes	O No

Dermatology

Skin rash	O Yes	O No
Eczema	O Yes	O No

Endocrinology

Growth Problems	O Yes	O No
Excessive Thirst	O Yes	O No
Weight loss	O Yes	O No
Excessive weight gain	O Yes	O No

Neurology

Weakness or numbness	O Yes	O No
Seizure disorder	O Yes	O No
Spina bifida	O Yes	O No

Ophthalmology

Diminished vision	O Yes	O No

Allergic/Immunologic

latex and/or other allergies	O Yes	O No
lupus	O Yes	O No

Hematologic/lymphatic

Swollen gland (lymph nodes)	O Yes	O No
Anemia	O Yes	O No
Unusual bleeding and/ or bruising	O Yes	O No