PEDIATRIC GYNECOLOGY
Associates

REVIEW OF SYSTEMS

Patient Name: ______________________________ Date of Appt ____________________
Date of Birth: ______________________________ Date of First Period ____________________

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

GENITOURINARY

Blood in urine	O Yes	O No
Painful urination	O Yes	O No
Complains of pain in the vagina	O Yes	O No
Vaginal discharge	O Yes	O No
Vaginal bleeding	O Yes	O No
Foul odor	O Yes	O No
Vaginal itching	O Yes	O No
Painful periods	O Yes	O No
Urinary complaints	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
Unwanted hair growth	O Yes	O No
Acne	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