pediatric
sports & spine associates

Review of Systems Questionnaire

Patient Name: _____ DOB: _____

PLEASE ANSWER EACH QUESTION

	Yes	No	
Constitutional:			
A. Recent weight changes?	☐	☐	_____
B. Weakness, fatigue or chills?	☐	☐	_____
Eyes:			
A. Difficulty seeing?	☐	☐	_____
B. Temporary loss of vision?	☐	☐	_____
Ears, Nose Throat:			
A. Problems with hearing?	☐	☐	_____
B. Hoarseness, sore throat?	☐	☐	_____
Cardiovascular:			
A. Chest pain/discomfort?	☐	☐	_____
B. Palpitations?	☐	☐	_____
Respiratory:			
A. Shortness of breath?	☐	☐	_____
B. Cough?	☐	☐	_____
Gastrointestinal:			
A. Constipation?	☐	☐	_____
B. Frequent Heartburn or Indigestion?	☐	☐	_____
C. Abdominal Pain?	☐	☐	_____
D. Blood in stool?	☐	☐	_____
Genitourinary:			
A. Blood in urine?	☐	☐	_____
B. Urinary frequency/urgency/pain?	☐	☐	_____
Endocrine:			
A. History of high/low blood sugar	☐	☐	_____
B. Thyroid problems	☐	☐	_____
Musculoskeletal:			
A. Joint pain?	☐	☐	_____
B. Joint swelling?	☐	☐	_____
Neurological:			
A. Fainting	☐	☐	_____
Psychiatric:			
A. Depression/Anxiety	☐	☐	_____
Skin:			
A. Rashes?	☐	☐	_____
B. Skin cancer/other problems?	☐	☐	_____
Heme/Lymph:			
A. Bleeding tendencies/bruising?	☐	☐	_____

Patient signature/Legal Guardian: _____ Date: _____

Relation to patient: _____

Provider Signature: _____ Date: _____