Children's Hospital of Pittsburgh | of UPMC

OUTPATIENT PEDIATRIC OTOLARYNGOLOGY REVIEW OF SYSTEMS

FORM NO. 2615 Rev. (12/11)

Patient Name

Medical Record Number

Birthdate

CHILDREN'S HOSPITAL OF PITTSBURGH DEPARTMENT OF PEDIATRIC OTOLARYNGOLOGY

REVIEW OF SYSTEMS Date of Visit: _____

Does you child currently have problems with (please indicate past problems with "P")

GENERAL ☐ **NO CHANGE SINCE LAST VISIT** **PLEASE CHECK**

Night Sweats	☐ Yes	☐ No	☐ P
Recurrent Fevers	☐ Yes	☐ No	☐ P
Failure to Gain Weight or Weight Loss	☐ Yes	☐ No	☐ P
Child's weight: _____ Child's Height: _____			
Change in activity level	☐ Yes	☐ No	☐ P

EYES ☐ **NO CHANGE SINCE LAST VISIT**

Wearing glasses/contact lenses?	☐ Yes	☐ No	→ Date of Last Exam: _____
Double Vision	☐ Yes	☐ No	☐ P
Injuries	☐ Yes	☐ No	☐ P
Itchy eyes	☐ Yes	☐ No	☐ P
Swollen/sore eyes	☐ Yes	☐ No	☐ P

EAR, NOSE, THROAT ☐ **NO CHANGE SINCE LAST VISIT**

Hearing Loss	☐ Yes	☐ No	☐ P
Wearing Hearing Aids	☐ Yes	☐ No	→ Date of Last Exam: _____
Ear Pain	☐ Yes	☐ No	☐ P
Ear Infections	☐ Yes	☐ No	☐ P
If Yes how many in past 6 months _____			
How many in past 12 months _____			
Ear pressure/fullness	☐ Yes	☐ No	☐ P
Ringing in Ears	☐ Yes	☐ No	☐ P → Check: ☐ Left ☐ Right ☐ Both
Balance Problems (dizziness, unsteadiness, failing)	☐ Yes	☐ No	☐ P
Drainage from Ears	☐ Yes	☐ No	☐ P → Check: ☐ Left ☐ Right ☐ Both
Nosebleeds	☐ Yes	☐ No	☐ P
Nasal Congestion	☐ Yes	☐ No	☐ P
Colored or thick nasal discharge	☐ Yes	☐ No	☐ P
Daytime cough	☐ Yes	☐ No	☐ P
Nighttime cough	☐ Yes	☐ No	☐ P
Headache	☐ Yes	☐ No	☐ P
Fever	☐ Yes	☐ No	☐ P
Postnasal drip/discharge	☐ Yes	☐ No	☐ P
Bad Breath	☐ Yes	☐ No	☐ P
Need to blow nose repeatedly	☐ Yes	☐ No	☐ P
Facial pain/pressure/edema	☐ Yes	☐ No	☐ P
Runny Nose	☐ Yes	☐ No	☐ P
Sneezing	☐ Yes	☐ No	☐ P
Mouth Breathing	☐ Yes	☐ No	☐ P
Frequent Throat Clearing	☐ Yes	☐ No	☐ P
Heartburn	☐ Yes	☐ No	☐ P
Sore Throat	☐ Yes	☐ No	☐ P → If Yes how many in a year? _____
Mouth Sores	☐ Yes	☐ No	☐ P
Noisy breathing/snorting	☐ Yes	☐ No	☐ P
Snoring	☐ Yes	☐ No	☐ P
Gasping and/or Choking during Sleep	☐ Yes	☐ No	☐ P
Apnea (stops breathing during sleep)	☐ Yes	☐ No	→ If Yes how many seconds? _____
Wake up during the night/Restless Sleep	☐ Yes	☐ No	☐ P
Bed Wetting	☐ Yes	☐ No	☐ P
Sleepwalking	☐ Yes	☐ No	☐ P
Hoarseness	☐ Yes	☐ No	☐ P
Difficulty Swallowing	☐ Yes	☐ No	☐ P

CARDIOVASCULAR ☐ **NO CHANGE SINCE LAST VISIT**

Heart Murmur	☐ Yes	☐ No	☐ P
Abnormal heart anatomy	☐ Yes	☐ No	☐ P
Has a physician ever recommended antibiotics prior to a surgical procedure (e.g. dental) because of a heart murmur?	☐ Yes	☐ No	☐ P

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RESPIRATORY ☐ NO CHANGE SINCE LAST VISIT	PLEASE CHECK		
Asthma/Wheezing	☐ Yes	☐ No	☐ P
Chronic Cough	☐ Yes	☐ No	☐ P
Bronchitis/Pneumonia	☐ Yes	☐ No	☐ P
Croup	☐ Yes	☐ No	☐ P
Shortness of Breath	☐ Yes	☐ No	☐ P
Bronchopulmonary Dysplasia	☐ Yes	☐ No	☐ P
GENITOURINARY ☐ NO CHANGE SINCE LAST VISIT			
Recurrent Urinary Tract Infections	☐ Yes	☐ No	☐ P
Blood in your child's Urine	☐ Yes	☐ No	☐ P
MUSCULOSKELETAL ☐ NO CHANGE SINCE LAST VISIT			
Broken Bones	☐ Yes	☐ No	☐ P → Please list _____
Neck Trauma	☐ Yes	☐ No	☐ P
INTEGUMENTARY ☐ NO CHANGE SINCE LAST VISIT			
Eczema	☐ Yes	☐ No	☐ P
Skin Disease	☐ Yes	☐ No	☐ P
NEUROLOGICAL ☐ NO CHANGE SINCE LAST VISIT			
Fainting Spells or "Blacking Out"	☐ Yes	☐ No	☐ P
Irritability	☐ Yes	☐ No	☐ P
Short attention span	☐ Yes	☐ No	☐ P
Seizures	☐ Yes	☐ No	☐ P
Speech difficulty	☐ Yes	☐ No	☐ P
Frequent Headaches or Migraines	☐ Yes	☐ No	☐ P
PSYCHIATRIC ☐ NO CHANGE SINCE LAST VISIT			
Anxiety	☐ Yes	☐ No	☐ P
Depression	☐ Yes	☐ No	☐ P
Other Psychiatric Disorder/Treatment	☐ Yes	☐ No	☐ P
ENDOCRINE ☐ NO CHANGE SINCE LAST VISIT			
Diabetes	☐ Yes	☐ No	☐ P
Thyroid Disease	☐ Yes	☐ No	☐ P
Excessive Thirst or Urination	☐ Yes	☐ No	☐ P
Hormone Problems	☐ Yes	☐ No	☐ P
Pregnancy	☐ Yes	☐ No	☐ P
HEMATOLOGICAL/LYMPHATIC ☐ NO CHANGE SINCE LAST VISIT			
Anemia	☐ Yes	☐ No	☐ P
Hemophilia/Easy Bleeding Tendencies	☐ Yes	☐ No	☐ P
Persistent Swollen Glands or Lymph Nodes	☐ Yes	☐ No	☐ P
Leukemia	☐ Yes	☐ No	☐ P
Sickle Cell Disease	☐ Yes	☐ No	☐ P
Blood Transfusions	☐ Yes	☐ No	☐ P
IMMUNOLOGIC ☐ NO CHANGE SINCE LAST VISIT			
Immunological Disorders (Immune Deficiency)	☐ Yes	☐ No	☐ P
Frequent infections (e.g. pneumonia, boils, and abscesses)	☐ Yes	☐ No	☐ P
Allergy tests	☐ Yes	☐ No	☐ P → Result _____
Flu vaccine or pneumococcal vaccine administered?	☐ Yes	☐ No	☐ P
Recent X-Ray, CAT scan, MRI or other test	☐ Yes	☐ No	

If Yes, which test, when and for what reason? _____

Other: Please add your comments and thoughts about your child's illness, how much impact it has on your and your child's life.

_____

A number of research studies are being conducted in our institution to help us better treat ear, nose, and throat diseases in children
Would you like your child to participate in a research study if eligible? ☐ Yes ☐ No

Completed by: _____ Relationship: _____ Date: _____

Medical History Reviewed by: _____ Date: _____ Time: _____