Child Neurology
Consultants of Austin

Review of Systems (Intake on Portal)

Patient Name: _____ Date of Birth _____

Other Physicians/Specialists Seen Since Last Visit: _____

Chief Complaint/Reason for the Visit: _____

Review of Systems (please circle any symptoms that your child has today for the visit or none):

1. ***General:*** none weightloss weight gain appetite loss appetite increase fever decreased energy

2. ***Cardiovascular:*** none palpitations leg swelling fast heart rate chest pain high/low blood pressure

3. ***Respiratory:*** none wheezing shortness of breath cough

4. ***Gastrointestinal:*** none nausea vomiting consitipation diarrhea jaundice abdominal pain blood in stool

5. ***Genitourinary:*** none blood in urine pain during urination need to urinate suddenly odor in urine cloudy urine increased urination decreased urination urine incontinence

6. ***Musculoskeletal:*** none weakness joint pain joint swelling muscle pain stiff neck

7. ***Skin:*** none rash dry skin excessive sweating itching skin lesions hair loss body hair acne

8. ***Neurological:*** none headache tingling numbness seizures difficulty with balance dizziness fainting trembling or shaking (tremor) snoring excessive sleepiness difficulty falling asleep blurred vision double vision ringing in the ears head injury slurred speech difficulty finding words memory lapses or loss abnormal movements

9. ***Psychological:*** none depressed anxiety behavior issues mood swings irritability aggression poor school performance daydreaming

10. ***Endocrine:*** none frequent urination excessive drinking of fluids heat/cold intolerance breast buds menstrual cycle irregularity heavy menstrual periods

11. ***Hematologic:*** none bruising bleeding nosebleeds gums bleeding swollen glands

Are there any updates to your past medical history, surgical history, or social history since your last visit?

Provider Signature of Review: _____ Date: _____