PHOENIX CHILDREN'S Medical Group®

Division of Pediatric Rheumatology

PATIENT HISTORY: REVIEW OF SYSTEMS

FILL OUT THESE FORMS BEFORE YOUR APPOINTMENT

Please check any problems (boxes) listed below which have significantly affected your child.

Person completing form ☐ Patient ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other:_____

Patient's Name_____ Date: _____ Date of last **eye exam:**_____

Constitutional
- ☐ Recent weight gain_____(amount)
- ☐ Recent weight loss_____(amount)
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever

Eyes
- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feels like something in eye
- ☐ Itching eyes

Ears−Nose−Mouth−Throat
- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Dryness in nose
- ☐ Runny nose
- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Dryness of mouth
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing

Cardiovascular
- ☐ Pain in chest
- ☐ Irregular heart beat
- ☐ High blood pressure
- ☐ Heart murmurs

Respiratory
- ☐ Shortness of breath
- ☐ Difficulty in breathing at night
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing (asthma)

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting of blood or coffee ground material
- ☐ Stomach pain relieved by food or milk
- ☐ Jaundice (yellow skin, eyes)
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools
- ☐ Heartburn

Genitourinary
- ☐ Pain or burning on urination
- ☐ Blood in urine
- ☐ Cloudy, "smoky" urine
- ☐ Pus in urine
- ☐ Discharge from penis/vagina
- ☐ Genital rash/ulcers

For Women Only:

Age when periods began:_____

Periods regular? ☐ Yes ☐ No

How many days apart? _____

Date of last period?_____

Dermatologic
- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Sun sensitive or sunburn easily or develop rash after being in the sun
- ☐ Tightness
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Hands/feet color changes in the cold

Neurological System
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Loss of consciousness
- ☐ Numbness or tingling of hands or feet
- ☐ Memory loss
- ☐ Night sweats

Psychiatric
- ☐ Excessive worries
- ☐ Anxiety
- ☐ Easily losing temper
- ☐ Depression
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

Endocrine
- ☐ Excessive thirst
- ☐ Excessive urination

Hematologic/Lymphatic
- ☐ Swollen glands
- ☐ Tender glands
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Transfusion/when

Allergic/Immunologic
- ☐ Frequent sneezing
- ☐ Increased susceptibility to infection
- ☐ Hives
- ☐ Eczema

Musculoskeletal
- ☐ Morning stiffness, lasting how long? _____Minutes _____Hours
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Low back pain
- ☐ Red color over joint
- ☐ Joint pain
- ☐ Joint swelling

List joints affected in the last 6 mos.

_____

_____

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Patient History: Review of Systems

PAST MEDICAL HISTORY

Does your child have or ever had: check if "yes"

☐ Cancer ☐ Heart problems ☐ Asthma
☐ Goiter ☐ Diabetes ☐ Tuberculosis
☐ Stomach ulcers ☐ Epilepsy/Seizures ☐ Rheumatic Fever
☐ Kidney disease ☐ Pneumonia ☐ Psoriasis
☐ Anemia ☐ HIV/AIDS ☐ High Blood Pressure

Other significant illness (please list)

_____

TRAVEL in last year: _____

PETS: _____

IMMUNIZATIONS: ☐ Chickenpox (when)_____
☐ Up−to−date ☐ Varicella (chickenpox) vaccine
☐ Date of last immunization (vaccine): _____

SOCIAL HISTORY

Who lives at home with patient? _____
Patient use: tobacco? ☐ Yes ☐ No Alcohol? ☐ Yes ☐ No
Do you use drugs for reasons that are not medical? ☐ Yes ☐ No
If yes, please list_____
Do you exercise regularly? ☐ Yes ☐ No Hours per week_____
Type of exercise:_____
Grade in school _____ Grades _____
# of days absent from school due to rheumatic disease?_____
How many hours of sleep do you get at night?_____
Number of times you wake up in the middle of the night?_____
Do you get enough sleep at night? ☐ Yes ☐ No
Do you wake up feeling rested? ☐ Yes ☐ No

Previous Operations

Type & Year	*Type & Year*
1.	3.
2.	4.

Any previous fractures? ☐ Yes ☐ No if yes, Describe: _____
Any other serious injuries? ☐ Yes ☐ No if yes, Describe: _____

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	Age	Medical Problems	Age at Death	Cause
Father				
Mother				

Number of sisters _____ Number of brothers_____ Number deceased_____
Medical problems of brothers and sisters:_____

Do you know of any blood relative who has or had: (check and give relationship)

☐ Psoriasis _____ ☐ Heart disease _____
☐ Lupus_____ ☐ High blood pressure _____
☐ Osteoarthritis (degenerative)_____ ☐ Thyroid disease _____
☐ Ankylosing Spondylitis_____ ☐ Stroke _____
☐ Rheumatoid arthritis_____ ☐ Colitis _____
☐ Childhood arthritis _____ ☐ Epilepsy/Seizures _____
☐ Gout_____ ☐ Asthma _____
☐ Rheumatic fever_____ ☐ Tuberculosis _____
☐ 'Growing pains'_____ ☐ Diabetes _____
☐ Cancer _____

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Patient History: Review of Systems

MEDICATIONS

Drug allergies: ☐ No ☐ Yes To what? _____

_____

Type of reaction: _____

PRESENT MEDICATIONS (List any medication you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc..)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped?		
			A Lot	Some	Not at All
1.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐

Natural or Alternative Therapies (chiropractic, magnets, acupuncture, massage, over−the−counter preparations, etc.)

_____

_____

PAST MEDICATIONS: (List any medication you have taken in the past that were useful and NOT useful − in relation to why you are being seen here today.)

USEFUL: _____

_____

NOT USEFUL: _____

_____

Please let us know if your child has been affected by pain due to his or her illness. Circle a number on the line below to indicate how much pain the illness has caused IN THE PAST WEEK:

Pain Visual Analog Scale (VAS)

No Pain **Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

_____ _____

Signature of Patient/ Legally Authorized Representative Relationship to Patient

_____ _____

Printed Name Date & Time

_____ _____

Practitioner Signature Date & Time

_____

Printed Name