

Atlanta Kids ENT, PC
INTERVAL HISTORY AND REVIEW OF SYSTEMS

Child's name: _____ **Birthday:** _____

Child's Weight: _____ **Pediatrician/Family Practitioner:** _____

Phone # : home: _____ **wk:** _____ **cell:** _____

Drug Allergies: _____

Child's Current Medications:

Reason for today's visit

1. _____

2. _____

Review of Systems:

Please indicate health problems that have occurred **since** your child's last visit

	Yes	No	Comments
Recent fever or weight loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye problems (cataract, blindness, etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear, nose or throat problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood abnormalities (anemia, etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart or blood pressure problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach or intestinal problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney or bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin problems (rash, acne, etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid problems or Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurology problems (seizure, headache, etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric problem (depression, etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory problems (asthma, etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal problems (joints, bones)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other not listed above	<input type="checkbox"/>	<input type="checkbox"/>	_____

Signature of responsible party: _____ Date: _____

Physicians' initials: _____

Date: _____