



**REVIEW OF SYSTEMS**

\*\*\* FOR OFFICE USE ONLY \*\*\*

11. Are you bothered by any of the following symptoms in the following body systems? Mark (✓) 'Yes' or 'No' for each.

Affix Patient Label Here

All Systems Negative Except Noted

GENERAL	YES	NO	RESPIRATORY	YES	NO
Always tired	( )	( )	Chest tightness	( )	( )
Chills / Fever	( )	( )	Cough (wet)	( )	( )
Loss of appetite	( )	( )	Cough (dry)	( )	( )
Night sweats	( )	( )	Coughing up blood	( )	( )
Recurrent infections	( )	( )	Frequent colds or bronchitis	( )	( )
Trouble sleeping	( )	( )	History of pneumonia	( )	( )
Weight gain / loss	( )	( )	Shortness of breath	( )	( )
			Wheezing	( )	( )

EYES	YES	NO	GASTROINTESTINAL	YES	NO
Darkness under eyes	( )	( )	Abdominal bloating	( )	( )
Drainage	( )	( )	Abdominal pain	( )	( )
Vision change	( )	( )	Bloody stools	( )	( )
Eye pain	( )	( )	Nausea or vomiting	( )	( )
Itchy eyes	( )	( )	Vomiting blood	( )	( )
Light sensitivity	( )	( )	Belching or excess gas	( )	( )
Red eyes	( )	( )	Constipation	( )	( )
Watery eyes	( )	( )	Indigestion / heartburn	( )	( )
			Diarrhea	( )	( )

HENT (Head)	YES	NO	GENTOURINARY	YES	NO
Headaches	( )	( )	Urinary frequency	( )	( )
Sinus pain	( )	( )	Painful urination	( )	( )
Sinus infections	( )	( )			

(Ears)			MUSCULOSKELETAL		
Ear ache/pain	( )	( )	Joint swelling	( )	( )
Decreased hearing	( )	( )	Stiffness	( )	( )
Ear drainage	( )	( )	Joint pain	( )	( )
Ear infections	( )	( )	Muscle aches / cramps	( )	( )
Ringing or popping ears	( )	( )	Redness	( )	( )

(Nose)			SKIN	YES	NO
Sneezing	( )	( )	Rash	( )	( )
Runny nose	( )	( )	Birthmarks	( )	( )
Loss of smell	( )	( )	Hives / welts	( )	( )
Stuffy nose	( )	( )	Itching	( )	( )
Itchy Nose	( )	( )	Dry skin	( )	( )
Nosebleeds	( )	( )	Change in skin color	( )	( )
Excessive snoring	( )	( )	Swelling	( )	( )
			Bruising	( )	( )
(Throat / Mouth)			Abrasions	( )	( )
Sore throat	( )	( )	Skin infections	( )	( )
Hoarseness / laryngitis	( )	( )			
Difficulty swallowing	( )	( )			
Loss of taste	( )	( )			
Itchy roof of mouth	( )	( )			

ALLERGIC	YES	NO
Seasonal allergies	( )	( )
Hay fever	( )	( )
Reaction to foods or drugs...	( )	( )

CARDIOVASCULAR	YES	NO	NEUROLOGIC	YES	NO
Shortness of breath w/exertion	( )	( )	Headaches	( )	( )
Bluish fingers or lips	( )	( )	Dizziness or poor balance	( )	( )
Near fainting	( )	( )			

HEMATOLOGIC/LYMP.	YES	NO
Swollen glands	( )	( )
Anemia / low blood	( )	( )

ENDOCRINE	YES	NO
Hair loss	( )	( )

List any other symptoms or concerns you have:

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Level 3 = 1 Area  
Level 4 = 2 - 9 Areas  
Level 5 = 10+ Areas

<b>ROS Level</b>		<b>Provider Initial</b>
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**PAST MEDICAL HISTORY**

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**12. MEDICATIONS.** List any prescriptions, including bronchodilators, antibiotics, etc. and over-the-counter medicines, including vitamins, supplements and herbals you are currently taking or have taken within 60 days.

a.	<u>Medication</u>	<u>Strength</u>	<u>How Often</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**13. OTHER ILLNESSES.** List any illnesses or conditions you have ever had.

a.	<u>Condition / Illness</u>	<u>Age</u>	<u>Currently Being Treated?</u>	<u>Current Physician</u>
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

<u>Current Status</u>			
<input type="checkbox"/> Resolved	<input type="checkbox"/> Active	<input type="checkbox"/> Stable	<input type="checkbox"/> Worse
<input type="checkbox"/> Resolved	<input type="checkbox"/> Active	<input type="checkbox"/> Stable	<input type="checkbox"/> Worse
<input type="checkbox"/> Resolved	<input type="checkbox"/> Active	<input type="checkbox"/> Stable	<input type="checkbox"/> Worse
<input type="checkbox"/> Resolved	<input type="checkbox"/> Active	<input type="checkbox"/> Stable	<input type="checkbox"/> Worse
<input type="checkbox"/> Resolved	<input type="checkbox"/> Active	<input type="checkbox"/> Stable	<input type="checkbox"/> Worse

**14. FEMALES ONLY** ( Not applicable)

a. Last Known menstrual period \_\_\_\_/\_\_\_\_/\_\_\_\_

b. Chance of pregnancy?  Yes  No

**15. IMMUNIZATIONS.**

a. Are your immunizations current?  No  Yes

b. Do you receive annual flu vaccines?  No  Yes

**16. REACTIONS.** Please list any food, drug, or insect reactions or side effects you currently have or have had at some point in your life.  None

a.	<u>Cause</u>	<u>Type of Reaction or Side Effect</u>			
_____	<input type="checkbox"/> Rash/hives	<input type="checkbox"/> Swelling	<input type="checkbox"/> Itching	<input type="checkbox"/> Short of Breath	
_____	<input type="checkbox"/> Rash/hives	<input type="checkbox"/> Swelling	<input type="checkbox"/> Itching	<input type="checkbox"/> Short of Breath	
_____	<input type="checkbox"/> Rash/hives	<input type="checkbox"/> Swelling	<input type="checkbox"/> Itching	<input type="checkbox"/> Short of Breath	
_____	<input type="checkbox"/> Rash/hives	<input type="checkbox"/> Swelling	<input type="checkbox"/> Itching	<input type="checkbox"/> Short of Breath	

b. Have you ever had allergy skin testing?  No  Yes

c. Have you ever been on allergy injections?  No  Yes

**17. SURGERIES / INJURIES.** List any surgeries or injuries since birth.

a.	<u>Surgery or Injury</u>	<u>Performed by</u>	<u>Complications?</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

b. Any previous injury to nose?  No  Yes

**18. HOSPITAL / ER VISITS.** List any hospital or ER visits within the last 5 yr

a.	<u>Reason</u>	<u>Length of Stay</u>	<u>Complications</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Outcome Where Age or Yr

Hospital Age or Yr

**19. PAST TRANSFUSIONS**

a. Have you ever had blood or blood product transfusions?  No  Yes

Provider Initial

**PEDIATRIC PAST MEDICAL HISTORY**

**\*\* Complete #20 - # 23 only if patient is a minor \*\***

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**20. PREGNANCY & BIRTH**

- a. Is your child yours by:  Birth  Adoption  Stepchild  Foster
- b. Birth weight: \_\_\_\_\_ Type of Delivery:  Vaginal  Caesarian
- c. Age of mother at time of delivery \_\_\_\_\_
- d.  Full term or  Premature How many wks premature? \_\_\_\_\_
- e. Any delayed separation of umbilical cord (> 1 month) ?  No  Yes
- f. Prolonged jaundice over 2 weeks?  No  Yes
- g. Intestinal obstructions during infancy?  No  Yes
- h. Any other newborn problems?  No  Yes

Affix Patient Label Here

**21. NUTRITION & FEEDING**

- a. Was your child breastfed?  No  Yes If so, how long? \_\_\_\_\_
- b. Was you child bottle-fed?  No  Yes If so, how long? \_\_\_\_\_
- c. Were formula changes required?  No  Yes
- d. Has your child had any feeding/dietary problems?  No  Yes

**22. DEVELOPMENT**

- a. Has you child had any of the following delays? Circle if so.  
 Walking                  Learning                  Talking
- b. Any difficulties with growth or weight gain?  No  Yes

**23. SCHOOL HISTORY**

- a. Did/does your child attend preschool?  No  Yes
- b. How many days of missed school in the last year due to illness? \_\_\_\_\_
- c. Is your child in daycare?  No  Yes  
 How many days per week? \_\_\_\_\_  
 At what age did they start daycare? \_\_\_\_\_
- d. What grade is your child in? (Circle one)  N/A  
 P    K    1    2    3    4    5    6-8    9-12
- e. School performance:  Above average  Average  Below average

**FAMILY HISTORY**

**24.** Place a check mark under the appropriate family member if they have experienced any of the following conditions or diseases. Write in any conditions or diseases not listed.

Condition	Mom	Mom's Mom	Mom's Dad	Dad	Dad's Mom	Dad's Dad	Sis.	Bro.	Other
Allergies / hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma / RAD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immune deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Provider Initial



**ENVIRONMENTAL HISTORY**

**PATIENT'S RESIDENCE**

Affix Patient Label Here

30. What is the age of your home?  0 – 10 years  11–15 years  16 – 20 years  > 20 years
31. How long have you lived at current residence?  1 year or less  1 – 5 years  6 - 10 years  over 10 years
32. What type of home do you live in?  Frame house  Brick house  Apartment  Mobile Home  Other \_\_\_\_\_
33. Where is your home located?  City  Suburb  Country / Rural  Farm  Near water  Other \_\_\_\_\_
34. Does your home have a basement?  No  Yes If “Yes” ⇒  Water leaks  Damp  Previous problems with leaks
35. What type of heating?  Central or  Space:  gas  electric  oil  wood  kerosene
36. What type of air conditioning?  Central  Window  None
37. How often are air filters changed?  N/A  Weekly  Monthly  Less often
38. What other “air” devices do you use?  Fans  Dehumidifiers  Humidifiers  Air filter/cleaner
39. Is there any noticeable mold or mildew?  No  Yes If “Yes”, where?  Bathrooms  Basement  Bedrooms  Kitchen
40. Is there any fume exposure?  No  Yes If “Yes”, what type?  Cleaning supplies  Aerosols  Fragrances  Paint / Varnish
41. Do you spend time at other residences?  No  Yes
42. Is there any animal exposure?  No  Yes If “Yes”, indicate the number of each animal. If other, write in what type and how any.

Animal Exposure							
Location	Dog	Cat	Bird	Rodent	Horse	Farm Animals	Other
At home, indoors							
At home, outdoors							
Other							
School / Sitter							

43. Do you have any indoor plants or flowers?  No  Yes If so, how many?  1 – 5  6 – 10  11 – 20  over 20
44. Have there been any pest problems?  No  Yes If so, what?  Roaches  Other insects  Mice  Other: \_\_\_\_\_
45. Where does the problem seem to be worse?  Bedroom  Living room  Kitchen  Basement  Garage  Indoors  Outdoors

**PATIENT'S BEDROOM**

46. Indicate the items found in patient's bedroom.  Mattress pad  Stuffed furniture  Heavy drapes  Venetian blinds  Carpeting  Bookcase  Quilts/Comforters  Stuffed toys  Plants
47. How many beds in bedroom?  1  2  3  4 or more
48. How many persons in bedroom?  1  2  3  4 or more
49. What type of mattress?  Spring  Foam  Bunk  Water  Crib  Other \_\_\_\_\_
50. What type of pillow?  Cotton  Feather  Foam  Polyester  Other \_\_\_\_\_
51. Are vinyl covers used?  No  On mattress  On pillows
52. What type of flooring?  Carpet  Hardwood  Tile  Linoleum

*Thank you for taking the time to complete this questionnaire! Please bring this with you for your appointment.*

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Level 4 – 1 element Level 5 – 2+ elements	<b>PMFSH</b> Level		Provider Initial
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