Child's Name: _____Date of birth:_____
Parent's Name: _____
Current Address:_____
_____
Phone Numbers with area code: home_____cell_____work_____
Email address:_____
Pediatrician: _____ Address/Phone:_____

Review of Systems

Please check the box if your child currently has any of the following symptoms

		Yes	No
General:	Fevers	☐	☐
	Weight Loss	☐	☐
	Chills	☐	☐
	Fatigue	☐	☐
Eyes:	Vision changes	☐	☐
	Red Eyes	☐	☐
	Itchy Eyes	☐	☐
Ears/Nose/Throat:	Ear Pain	☐	☐
	Nasal Congestion	☐	☐
	Sore Throat	☐	☐
	Hoarseness	☐	☐
	Trouble Hearing	☐	☐
Cardiovascular:	Chest Pain	☐	☐
	Racing Heart	☐	☐
Respiratory:	Cough	☐	☐
	Shortness of Breath	☐	☐
	Wheezing	☐	☐
	Snoring	☐	☐
	Restless Sleeping	☐	☐
	Trouble breathing with sleep	☐	☐
Neurological:	Headache	☐	☐
Gastrointestinal:	Nausea	☐	☐
	Vomiting	☐	☐
	Diarrhea	☐	☐
	Constipation	☐	☐
	Abdominal Pain	☐	☐
	Heart Burn	☐	☐

		Yes	No
Genitourinary:	Painful urination	☐	☐
Musculoskeletal:	Muscle Pain	☐	☐
	Joint Stiffness	☐	☐
	Weakness	☐	☐
Skin:	Rash	☐	☐
Allergic:	Seasonal Allergies	☐	☐
	Sneezing	☐	☐

Please check below if you would like to speak with a:

- ☐ Nutritionist
- ☐ Clinical Psychologist
- ☐ Social Worker
- ☐ Nurse
- ☐ Parent of a child with a pulmonary Condition
- ☐ If you would like to be added to an email list of parents with children who have chronic respiratory conditions
  Email address: _____

If checked, please provide **a brief explanation of your concern/needs**

_____
_____
_____
_____
_____
_____
_____
_____