

NAME \_\_\_\_\_ DOB \_\_\_\_\_ DATE \_\_\_\_\_

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING CURRENTLY?	CHECK IF YES	DOES YOUR CHILD HAVE ANY OF THE FOLLOWING CURRENTLY?	CHECK IF YES
<b>CONSTITUTIONAL</b>		<b>GENITOURINARY</b>	
FEVER		PAINFUL URINATION	
CHILLS		BLOOD IN URINE	
FATIGUE		URINARY TRACT INFECTION	
CHANGE IN APPETITE		<b>ENDOCRINE</b>	
<b>SKIN</b>		CHANGE IN ENERGY LEVEL	
RASH		WEIGHT LOSS	
ITCHING AND HIVES		ABOVE NORMAL WEIGHT GAIN	
REDNESS		EXCESSIVE THIRST	
<b>HEAD AND EYES</b>		<b>NEUROLOGIC</b>	
HEADACHE		WEAKNESS	
VISUAL CHANGE		HEADACHE	
EYE DISCHARGE		NUMBNESS IN ARMS OR LEGS	
DIZZY		<b>MUSCULOSKELETAL</b>	
EYE REDNESS		JOINT PAIN	
<b>EAR NOSE AND THROAT</b>		MUSCLE PAIN	
EAR PAIN		SWELLING	
SINUS PRESSURE		<b>PSYCH</b>	
SORE THROAT		ANXIETY	
NASAL DISCHARGE		DEPRESSION	
<b>RESPIRATORY</b>		INSOMNIA	
SHORTNESS OF BREATH		<b>HEME/LYMPH</b>	
WHEEZE		EASY BRUISING	
COUGH		SLOW CLOTTING	
<b>HEART</b>		SWOLLEN GLANDS	
CHEST PAIN		<b>ALLERGIC/IMMUNOLOGIC</b>	
FAINTING		DRUG REACTIONS	
HEART PALPITATIONS		REACTION TO ANESTHESIA	
<b>GASTROINTESTINAL</b>			
NAUSEA			
VOMITING			
DARK TARRY STOOLS			
DIARRHEA			
CONSTIPATION			