Akron Children's Hospital

DIVISION OF PEDIATRIC ENDOCRINOLOGY
REVIEW OF SYSTEMS QUESTIONNAIRE

Today's Date:

Patient's Name: | **Date of Birth:**

WHO IS FILLING OUT THIS FORM? ☐ **MOTHER** ☐ **FATHER** ☐ **PATIENT** ☐ **OTHER**

PHARMACY **SPECIALTY PHARMACY**

Do you need 90 day Prescriptions? ☐ **Yes** ☐ **No**

ANY CONCERNS THAT YOU WOULD LIKE TO BE ADDRESSED?

HAS YOUR CHILD BEEN EXPERIENCING ANY OF THE FOLLOWING:

Constitutional:

- ☐ Excessive Fatigue
- ☐ Difficulty Sleeping
- ☐ Excessive Appetite
- ☐ Poor Appetite / Feeding Difficulty
- ☐ Excessive Weight gain
- ☐ Excessive Weight loss
- ☐ Developmental Delay

Eyes:

- ☐ Wear Glasses or Contacts
- ☐ Blurred Vision

Ears, nose, mouth, throat:

- ☐ Decreased hearing
- ☐ Decreased ability to smell
- ☐ Frequent Nose bleeds
- ☐ Difficulty swallowing
- ☐ Change in voice

Heart/Vascular:

- ☐ Chest Pain
- ☐ Palpitations
- ☐ Heart racing

Respiratory:

- ☐ Difficulty breathing
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough

Immunology:

- ☐ Frequent yeast infections

Gastrointestinal:

- ☐ Frequent abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation

Neurologic:

- ☐ Frequent headaches
- ☐ Seizures/ Convulsions
- ☐ Tremor
- ☐ Tingling/numbness in hands/feet
- ☐ Dizziness
- ☐ Fainting
- ☐ Confusion

Skin:

- ☐ Rashes
- ☐ Change in skin color
- ☐ Excessively Dry skin
- ☐ Excessively Oily skin
- ☐ Acne
- ☐ Easy bruising
- ☐ Stretch marks
- ☐ Male pattern hair growth (for girls)
- ☐ Dry, brittle hair
- ☐ Hair loss
- ☐ Flushing

Musculoskeletal:

- ☐ Joint pain
- ☐ Muscle pains
- ☐ Muscle cramps
- ☐ Fractures

Endocrinologic:

- ☐ Excessive thirst
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Puberty too early (before age 8)
- ☐ Puberty too late (after age 16)
- ☐ Adult body odor
- ☐ Nipple drainage

Girls:

Age of first period

Date of last period

- ☐ Heavy periods
- ☐ Irregular periods

Boys:

- ☐ Breast tissue

Mental Health Depression:

- ☐ Anxiety/ Nervousness
- ☐ Depression
- ☐ Agitation/ Irritability
- ☐ Mood swings

Please list any other healthcare specialists who are currently involved in your child's care:

Have you been to the ER or your primary care physician within the last 6 months? ☐ Yes ☐ No

If yes, for what reason?

Any updates to your family history ? ☐ Yes ☐ No

Any changes to your child's social situation? (change in school, living situation, death of family member, etc?) ☐ Yes ☐ No

School Name: **Grade:**

Akron Children's Hospital

-FOR DIABETES PATIENTS ONLY-

Please complete prior to being called back

Patient Name _____ **DOB** _____

Please circle correct medication: Novolog ☐ or Humalog ☐

Meal	**Time**	**Approx. # of carbs**
Breakfast	_____	_____ grams
Morning Snack	_____	_____ grams
Lunch	_____	_____ grams
Afternoon Snack	_____	_____ grams
Dinner	_____	_____ grams
Bedtime	_____	_____ grams

Insulin Pump Brand _____

Have you independently made changes to your child's insulin/pump settings since last visit (circle answer)? ☐ **Yes or** ☐ **No**

INJECTIONS ONLY

Lantus/Levemir _____ units at _____AM/PM

Meal	**I:C Ratio**
Breakfast	___
Lunch	_____
Dinner	_____

Correction:

_____ unit for every _____ mg/dL starting at _____

Comments/Concerns (Is there anything you want to discuss today):

Print forms