Icahn School of Medicine at Mount Sinai

The Sol and Margaret Berger Department of Urology
Pediatric Urology

REVIEW OF SYSTEMS

In order for our patients to get the most out of each appointment, we ask that you take the time to fill out this form before being called into the exam rooms. Thank you for your understanding and cooperation.

Patient Name: _____ **Date of Birth:** _____
(Last) (First)

Constitutional Symptoms:
□ Yes □ No Fever/Chills
□ Yes □ No Poor Growth
□ Yes □ No Poor Appetite
□ Yes □ No Poor Energy
Comment:
_____

Allergies/Immunologic:
□ Yes □ No Hay Fever
□ Yes □ No Medication Allergies
Comment:
_____

Neurological:
□ Yes □ No Tremors
□ Yes □ No Dizziness
□ Yes □ No Numbness/Tingling
Comment:
_____

Gastrointestinal:
□ Yes □ No Abdominal Pain
□ Yes □ No Nausea/Vomiting
□ Yes □ No Constipation
□ Yes □ No Soiling Underpants
Comment:
_____

Cardiovascular:
□ Yes □ No Chest Pain
□ Yes □ No High Blood Pressure
Comment:
_____

Psychological:
□ Yes □ No Depression
□ Yes □ No Attention Deficit
□ Yes □ No Obsessive/Compulsive
Comment:
_____

Integumentary:
□ Yes □ No Skin Rash
□ Yes □ No Eczema/Dry Skin
□ Yes □ No Persistent Itching
Comment:
_____

Musculoskeletal:
□ Yes □ No Joint Pain
□ Yes □ No Neck Pain
□ Yes □ No Back Pain
Comment:
_____

Genitourinary:
□ Yes □ No Urinary Retention
□ Yes □ No Pain/Burning with Urination
□ Yes □ No Frequent Urination
Comment:
_____

Respiratory:
□ Yes □ No Wheezing
□ Yes □ No Frequent Cough
□ Yes □ No Shortness of Breath
Comment:
_____

Hematologic/Lymphatic
□ Yes □ No Swollen Glands
□ Yes □ No Blood Clotting Problems
Comment:
_____