dell children's
medical center of central texas
A member of the Seton Family of Hospitals

Craniofacial Center
Review of Systems

The Craniofacial Center at Dell Children's Medical Center

Does your child have or have he or she previously had any of the following problems?

Constitutional

Good overall health recently	No	Yes
Recent change in weight	No	Yes
Gaining weight after birth (baby)	No	Yes
Fever	No	Yes

Eyes

Eye disease or injury	No	Yes
Corrective vision (glasses)	No	Yes
Eye crossing	No	Yes
Glaucoma	No	Yes
Double vision	No	Yes
Change in vision	No	Yes
Eye Surgery	No	Yes

Ears, nose, mouth & throat

Nose bleeds	No	Yes
Bleeding gums	No	Yes
Recent dental problems	No	Yes
Difficulty with swallowing	No	Yes
Pain with swallowing	No	Yes
Ear pain	No	Yes
Difficulty/pain with jaw opening	No	Yes
Hoarseness	No	Yes
Change in voice	No	Yes
Change in hearing/hearing loss	No	Yes
Failed hearing screen	No	Yes
Ear infections	No	Yes
Chronic congestion	No	Yes
Sinusitis	No	Yes

Cardiovascular

Heart trouble/Heart attack	No	Yes
Sweats with feeding	No	Yes
Shortness of breath	No	Yes
Murmur	No	Yes
Turning Blue	No	Yes
Fast heart rate	No	Yes
Heart palpitations	No	Yes
Fainting	No	Yes
Congenital heart disease	No	Yes

Respiratory

Chronic or frequent coughs	No	Yes
Asthma or wheezing	No	Yes
Fast respirations	No	Yes
Bronchitis	No	Yes

Gastrointestinal

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movement	No	Yes
Frequent spitting	No	Yes
Abdominal pain	No	Yes
Reflux	No	Yes
Feeding difficulties	No	Yes
Constipation	No	Yes
Gastrointestinal disease	No	Yes

Airway Symptoms/Sleep Apnea

Noisy breathing	No	Yes
Snoring	No	Yes
Restful sleep	No	Yes
Difficulty concentrating	No	Yes
Difficulties staying awake during day	No	Yes
Fall asleep doing routine tasks	No	Yes
Use CPAP/BiPAP	No	Yes
Been diagnosed w/ Sleep Apnea	No	Yes

Genitourinary

Burning or painful urination	No	Yes
Blood in urine	No	Yes
Frequent/Urgent urination	No	Yes
Urinary infections	No	Yes
Hernias	No	Yes

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Does your child have or have he or she previously had any of the following problems?

Integumentary (skin, breast)		
Skin rashes	No	Yes
Birth marks	No	Yes
Skin lesions	No	Yes

Neurological		
Light headed or dizzy	No	Yes
Numbness or tingling sensations	No	Yes
Paralysis	No	Yes
Seizures	No	Yes
Head injury	No	Yes
Weakness/lethargy	No	Yes
Change in school performance	No	Yes
Change in behavior	No	Yes
Headache	No	Yes
Irritability	No	Yes
Balance or coordination problems	No	Yes
Tremors	No	Yes

Endocrine		
Gland or hormone problem	No	Yes
Thyroid disease	No	Yes
Diabetes	No	Yes
Heat or cold intolerance	No	Yes
Excessive thirst	No	Yes
Abnormal newborn screen	No	Yes

Hematologic/Lymphatic		
Slow to heal cuts; bruising	No	Yes
Anemia	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

Musculoskeletal		
Join swelling, stiffness, or pain	No	Yes
Major fractures, sprains, or strains	No	Yes
Back pain or spine abnormalities	No	Yes
Bone, joint, or muscle problems	No	Yes
Hip dysplasia	No	Yes
Club foot	No	Yes

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