

Pediatric Neurosurgery Center  
**Review of Systems**

The Pediatric Neurosurgery 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
Activity Intolerance	No	Yes
Fatigue	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
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
Choking	No	Yes

**Cardiovascular**

Heart trouble	No	Yes
Sweats with feeding	No	Yes
Shortness of breath	No	Yes
Murmur	No	Yes
Turning Blue	No	Yes

**Respiratory**

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

**Gastrointestinal**

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Constipation	No	Yes
Fecal Intolerance	No	Yes
Frequent spitting	No	Yes
Abdominal pain	No	Yes
Reflux	No	Yes

**Airway Symptoms**

Noisy breathing	No	Yes
Snoring	No	Yes
Restful sleep	No	Yes
Difficulty concentrating	No	Yes
Difficulty staying awake during day	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
Urinary Incontinence	No	Yes

**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
Headaches	No	Yes
Head injury	No	Yes
Weakness	No	Yes
Arm/leg pain	No	Yes
Back pain	No	Yes
Syncope	No	Yes
Balance problems	No	Yes
Learning problems	No	Yes
Behavior problems	No	Yes

**Psychiatric**

Memory loss or confusion	No	Yes
Depression	No	Yes
Development delay	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

**Hematologic/Lymphatic**

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

**OTHER:**

Loss of milestones	No	Yes
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PROVIDER SIGNATURE: \_\_\_\_\_