Cardiology Associates of Mobile
Pediatric Cardiology
Phone: 251-434-9177
Fax: 251-432-1059

Patient Name: _____
Date: _____
Chart #: _____

Patient Review of Systems

Please check any of the following symptoms that the patient has been experiencing:

CONSTITUTIONAL	RESPIRATORY
☐ Weight Loss or poor weight gain	☐ Shortness of Breath
☐ Fever	☐ Poor exercise tolerance
☐ Change in appetite	
	MUSCLE / SKELETAL
GASTROINTESTINAL	☐ Muscle Weakness
☐ Vomiting	☐ Muscle Soreness
☐ Diarrhea	☐ Joint pain or swelling
☐ Stomach pain	☐ Back pain
☐ Constipation	
	INTEGUMENTARY
ENT	☐ Recent rashes
☐ Sore throat	☐ Skin discoloration
☐ Earache	☐ Blue or pale appearance of the face
☐ Cold symptoms	☐ Nodules or tumors on the skin
☐ Hearing problems	☐ Birthmarks
☐ Speech problems	
☐ Mouth sores	**NEUROLOGIC**
	☐ Abnormal coordination/weakness of muscles
CARDIOVASCULAR	☐ Delay in developing motor or verbal skills
☐ Blueness around the mouth or lips	
☐ Chest pain	**HEMOTOLOGIC**
☐ Irregular or rapid heart beat	☐ Bruises and bleeds easily
☐ Dizziness or fainting	☐ Swollen lymph nodes
☐ Fast or labored breathing	
☐ Slow feeding (> than 20 minutes to take a bottle)	**PSYCHIATRIC**
☐ Fluid retention	☐ Disciplinary problems at home or school
☐ Cough	☐ Abnormal interaction with peers or family
☐ Wheezing	☐ Substance abuse (alcohol, cigarettes or drugs)

Family and Social History	
Are there any relatives of the patient who have heart disease, diabetes, high blood pressure, strokes, cancer, sickle cell anemia or seizures ? ☐ YES ☐ NO	
If Yes, please explain further:	
Do any other illness run in the family ? ☐ YES ☐ NO If Yes, please list illness and relative :	
Who lives in the same house as the patient ?	
If the patient is in school, what grade is he/she in and is their performance satisfactory ? Grade Level _____ Performance: (please select) ☐ Satisfactory ☐ Non-satisfactory	
Is the patient involved in athletics ?	☐ YES ☐ NO