Pediatrics Northwest, P.S.

Allergy . Immunology . Pulmonary
Jeffrey Jacobs, M.D.
Lawrence Larson, D.O.
Timothy Murphy, M.D.
David Ricker, M.D.

Patients Name: ______________________________
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Date of Birth: __________

Review of Symptoms

Instructions: Please check each word that applies for symptoms.

General Health		Excellent	Good	Fair	Poor
Full Body	None	Fever/Chills	Night Sweats	Fatigue	Weakness
Head	None	Headache	Trauma	Sinus pressure	
Eyes	None	Itchy/Redness	Swelling	Discharge	Cataracts/Glaucoma
Ears	None	Chronic infections Ringing	Pain Vertigo	Hearing problems Ear tubes	Discharge
Nose	None	Obstruction Dryness Itchy	Drainage Frequent colds Polyps	Post nasal drip Sinus Infection Snoring	Bleeding Sneezing Reduced sense of smell
Mouth/Throat	None	Itching Throat clearing Tonsillectomy/Adenoidectomy Age:______	Taste change Post nasal drip	Mouth sores Hoarseness	Sore throat Tonsillitis
Skin	None	Itching Hives	Dryness Eczema	Hair/nail changes Swelling	Rashes Infections
Pulmonary	None	Chronic Cough: Day Night short of breath	Chest Tightness	Sputum(phlegm) Pain	Wheeze Coughing up Blood
Gastrointestinal	None	Nausea Gas	Vomiting Reflux	Diarrhea Unusual stools	Constipation Blood in stool
Infections	None	Colds Pneumonia	Sinusitis Chronic diarrhea	Ear infections	Bronchitis
Weight Change	None	Failure to Thrive	Number of pounds________lbs	Lost	Gained over ______years
Heart	None	Palpitations High blood Pressure	Pain Low BP	Swelling	Arrhythmias
Genital/Urinary	None	Burning Blood in urine	Pain Sores	Frequency	Infections
Blood & Hormonal	None	Thyroid Transfusions	Diabetes Lymph node enlargement	Cushings	Anemia
Bones, Joints Muscles	None	Pain	Swelling	Deformity	
Neurologic	None	Fainting Coordination Problems	Seizures	Gait Problems Weakness	Speech Problems

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Reviewed______________________________**RN/MA**