# TEMESCAL CREEK MEDICINE

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# REVIEW OF SYSTEMS: ADOLESCENT

**PATIENT NAME:** _____ **DATE:** _____

Please take a moment to complete the following. In the last **3 months** have you experienced any of the following? Please indicate **YES** or **NO** and **explain** if appropriate.

| **GENERAL** | **Yes** | **No** | **If YES, please explain further:** |
|---|---|---|---|
| | ☐ | ☐ | Recurrent fever or chills? |
| | ☐ | ☐ | Unintentional weight loss? |
| | ☐ | ☐ | Recurrent fatigue or malaise? |
| **NEUROLOGIC** | **Yes** | **No** | |
| | ☐ | ☐ | Frequent dizziness? |
| | ☐ | ☐ | Fainting? |
| | ☐ | ☐ | Weakness in arms or legs? |
| **CARDIAC** | **Yes** | **No** | **Do you have:** |
| | ☐ | ☐ | Shortness of breath with normal activity? |
| | ☐ | ☐ | Palpitations (sensation of heart beating in your chest)? |
| **SKIN** | **Yes** | **No** | |
| | ☐ | ☐ | Rash ? |
| | ☐ | ☐ | New skin lesions, lumps or bumps? |
| | ☐ | ☐ | Moles that are changing color or size? |
| **HEENT** | **Yes** | **No** | |
| | ☐ | ☐ | Headaches that are new or changing in frequency or severity? |
| | ☐ | ☐ | Non-healing mouth sores? |
| | ☐ | ☐ | Swollen glands or neck lumps? |
| **RESPIRATORY** | **Yes** | **No** | |
| | ☐ | ☐ | Cough that is ongoing, produces phlegm or is changing? |
| | ☐ | ☐ | Difficulty breathing? |
| | ☐ | ☐ | Wheezing? |
| | ☐ | ☐ | Do you smoke or are you exposed to 2nd hand smoke? |
| **GASTROINTESTINAL** | **Yes** | **No** | |
| | ☐ | ☐ | Heart Burn or Acid Reflux? |
| | ☐ | ☐ | Recurrent nausea or vomiting? |
| | ☐ | ☐ | Recurrent diarrhea or constipation? |
| | ☐ | ☐ | Recurrent abdominal pain or cramping? |
| **GENITOURINARY** | **Yes** | **No** | |
| | ☐ | ☐ | Pain with urination? |
| | ☐ | ☐ | Dark or reddish urine? |
| **MUSCULOSKELETAL** | **Yes** | **No** | |
| | ☐ | ☐ | Painful or swollen joints? (If yes, which ones?) |
| **INFECTIONS** | **Yes** | **No** | |
| | ☐ | ☐ | Do you feel you are at risk for HIV infection? |
| | ☐ | ☐ | Have you ever been exposed to or treated for tuberculosis? |
| | ☐ | ☐ | Have you ever had a blood transfusion? |
| | ☐ | ☐ | Sexually transmitted diseases? |

**PLEASE TURN OVER AND COMPLETE OTHER SIDE**

Please take a moment to complete the following. In the last **3 months** have you experienced any of the following? Please indicate **YES** or **NO** and **explain** if appropriate.

| **PREVENTION** | **Yes** | **No** | |
|---|---|---|---|
| | ☐ | ☐ | Do you wear sunscreen in the sun? |
| | ☐ | ☐ | Are you frequently exposed to loud noises, such as concerts, earphones or machinery? |
| | ☐ | ☐ | Do you wear a seatbelt when riding in a car, truck or van? |
| | ☐ | ☐ | Do you wear a helmet when skateboarding, rollerblading or riding a bike? |
| **REST & RECOVERY** | **Yes** | **No** | |
| | ☐ | ☐ | Do you have trouble falling or staying asleep? |
| | ☐ | ☐ | Do you wake feeling rested? |
| | ☐ | ☐ | How many hours per day do you watch TV or use a computer? |
| | How would you rate your energy on a scale of 1-10, with 10 being the most energy? | | |
| | ☐ How many hours of sleep do you get on average? | | |
| **STRESSORS** | **Yes** | **No** | In the past year have there been any changes in your family (check all that apply) |
| | ☐ | ☐ | Marriage |
| | ☐ | ☐ | Separation or divorce |
| | ☐ | ☐ | Loss of job |
| | ☐ | ☐ | Move to a new neighborhood |
| | ☐ | ☐ | Change to a new school |
| | ☐ | ☐ | Birth |
| | ☐ | ☐ | Serious illness |
| | ☐ | ☐ | Death |
| | ☐ | ☐ | Other changes/stresses? (explain) |
| **GYNECOLOGIC** | **Yes** | **No** | (FEMALE) |
| | ☐ | ☐ | Have you ever had a menstrual period? If YES, when was your last menstrual period? _____ |
| | ☐ | ☐ | Painful or heavy menstrual periods? |
| **PSYCHOLOGICAL** | **Yes** | **No** | |
| Read Carefully → | ☐ | ☐ | Do you feel safe at home? |
| | ☐ | ☐ | Anxiety? |
| | ☐ | ☐ | Little interest or pleasure in doing things? |
| | ☐ | ☐ | Feeling Down, Depressed or Hopeless? |
| | ☐ | ☐ | Suicidal thoughts? |
| | ☐ | ☐ | Social problems that you feel interfere with your mental or physical health? |
| During the PAST 12 MONTHS, did you: | | | |
| | ☐ | ☐ | Drink any alcohol (more than a few sips)? |
| | ☐ | ☐ | Use and marijuana? |
| | ☐ | ☐ | Use anything else to get high? ("anything else" includes illegal drugs, over the counter drugs, prescription drugs, and things that you sniff or "huff") |