University of Florida Date_____/_____/_____
Pediatric Review of Systems

Please take a few minutes to answer these questions, this will allow us to provide you with better and more complete care.

Child's Name: _____ _ **Primary Care Physician (address /telephone)**
Parent's Name: _____ _____
Home Phone: _____Cell:_____ _____
Address: _____ _____ _____
_____
Email address _____ _____
Medication/Food Allergy/ Reactions: _____/_____/_____

Pease check all that currently apply:

	Pain		Fever		Rectal Prolapse
	Snoring		Vomiting		Problems eating/ Too busy to eat/ No appetite
	Stuffy nose		Nausea		Ringing in ears
	Sore throat		Diarrhea		Excessive thirst
	Sinus pain/facial pressure		Constipation		Frequent urination
	Headaches		Reflux		Waking up at night to urinate
	Weight loss				

CHEST:

Changes in Sputum: □ Yes □ No Increase: □Yes □ No Amount: _____
Color: _____ Blood? □Yes □No

Cough: □None □Occasional □Daily □Cough that wakes your child

Wheezing? □Yes □No

Airway Clearance Methods: □None □ Flutter □ PEP □ Clapping (CPT) □Vest □Acapella □ AD □CPPD □Other_____

How often?: □1 time/day □ 2 times/day □ 3 /times per day □other_____

Oxygen: □none □as needed □ night □CPAP □BIPAP

GASTROINTESTIONAL:
Since my last clinic visit my food intake: □ normal □ increased □ decreased

Bowel Movements: Number per day ____ □Loose □Greasy/oily □Sink □Float □Normal □Bad odor □Large
Gas: □None □Occasional □Daily

How often do you take your **Enzymes** and when? (Check all that apply)
□never □with most meals (when I remember) □with all meals and snacks □with a glass of milk □15-30 minutes before meal
□when you start to eat □in the middle of a meal or snack □after finishing the meal □whenever you remember

In an average week, how many days do you take your **Enzymes**? (circle one) 0 1 2 3 4 5 6 7
In an average week, how many days do you take your **Vitamins**? (circle one) 0 1 2 3 4 5 6 7

Do you use any **nutritional supplements** like (carnation instant breakfast, ensure, boost, scandishakes)?

□Yes □No What Brand? _____ How much? _____

MEDICATIONS:
Bronchodilators - □Albuterol □Xopenex □MDI □ Neb □ Daily □ Twice a day

Enzymes- list name/dose _____

Vitamins- What brand/form/dose _____ Do you take it with food??_____

TOBI- □ Daily □Twice a day □ Every month □Every other month □Continuous

Colistin- □ Daily □Twice a day □ Every month □Every other month □ Continuous

Zithromax-□250 □500, □M-W-F □other_____

Pulmozyme- 2.5mg □Daily □Twice a day

Nasal Sprays- □Flonase □Normal Saline □other _____□ Daily □ Twice a day

Hypertonic Saline- □Once a day □Twice a day

Insulin/Oral Diabetic medication- _____ _____
List all other Medications/ Herbs/ Over the Counter Meds:
_____ _____ _____

Since your last visit, have you been **hospitalized**? □No □Yes, if so when and where?_____

Since your last visit, have you had **home IV's**? □No □Yes, if so when and for how long?_____
Since your last visit, have you been on **oral antibiotics**? □No □Yes

Social
Exercise/ Sports: _____
School/Daycare: _____
Tobacco use: (if yes how much) _____ Drug use : (if yes how much)_____

Changes in school/work performance: Days missed_____?

Changes in mood □Sadness □Anxiety □Anger □Suicidal thoughts □Other_____

Difficulty with tasks □Concentrating □Completing

Insurance issues concerns yes no
Educational:
What is the main thing you want to learn or would like help with managing your cystic fibrosis? _____
_____
Would you like to be added to an email list of parents with children who have chronic respiratory issues???
yes: _____No_____
Would you like to speak with: Nutrition □
Nursing □
Social Work □
Parent of a child with a chronic respiratory condition □

INFORMATION REVIEWED BY:_____