



Fridley Children's & Teenagers'
Medical Center
Love...Kindness...Excellence

Date: _____

MEDICAL HISTORY FORM-page 2

Patient Name: _____	DOB: _____
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Review of Systems: Please check **NO** or **YES** Box to indicate if your child currently has any problems in one or more of the following areas. **If yes, please explain the problem.**

Area	NO	YES	Explanation/comments:
General/Constitutional: (fever, weight loss or gain, tired)			
Eyes: (blurred vision, eye pain, discharge, etc)			
Ears, Nose, Throat, Mouth: (hearing loss, ear ache, nasal congestion, chronic cough, nasal drip, dry mouth, allergies, hay fever, etc)			
Respiratory: (asthma, chronic bronchitis, wheezing, shortness of breath, etc)			
Cardiovascular: (diabetes, hypertension, high cholesterol, heart problems)			
Gastrointestinal: (diarrhea, constipation, hernia, ulcers, etc)			
Genitourinary: (painful urination, frequent urination, impotence, jaundice, etc.)			
Lymphatic: (anemia, bleeding problems, problems with blood transfusions, etc)			
Musculoskeletal: (arthritis, joint pain, muscle pain, cramps, stiffness, swelling, etc)			
Skin: (pimples, warts, growths, rashes, etc)			