

ASSESSMENT ADDENDUM – PEDIATRICS

SYSTEMS ASSESSMENT

OBSERVATIONS AND MEASUREMENTS	NORMAL FINDINGS	ABNORMAL SIGNS		HISTORY	COMMENTS	
	CNS <input type="checkbox"/>	<input type="checkbox"/> Tremors <input type="checkbox"/> Dizziness <input type="checkbox"/> Vertigo <input type="checkbox"/> Unsteadiness <input type="checkbox"/> Disoriented <input type="checkbox"/> Memory loss <input type="checkbox"/> Headache <input type="checkbox"/> Other:	<input type="checkbox"/> Pupils unequal <input type="checkbox"/> Speech slurred <input type="checkbox"/> Paraplegia <input type="checkbox"/> Quadriplegia <input type="checkbox"/> Hemiplegia <input type="checkbox"/> Hemiparesis <input type="checkbox"/> Motor/Sensory loss	<input type="checkbox"/> Seizure disorder <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Headaches <input type="checkbox"/> Traumatic brain injury <input type="checkbox"/> Other:		
	CVS <input type="checkbox"/>	<input type="checkbox"/> Heart murmur <input type="checkbox"/> Cyanosis <input type="checkbox"/> Edema <input type="checkbox"/> Other:	<input type="checkbox"/> Arrhythmias <input type="checkbox"/> Tachycardia <input type="checkbox"/> Bradycardia	<input type="checkbox"/> Anemia <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Blood disorder <input type="checkbox"/> Other:		
	RESP <input type="checkbox"/>	<input type="checkbox"/> Shallow <input type="checkbox"/> Rapid <input type="checkbox"/> Slow <input type="checkbox"/> Dyspnea <input type="checkbox"/> Other:	<input type="checkbox"/> Wheezing <input type="checkbox"/> Cough <input type="checkbox"/> SOB	<input type="checkbox"/> Asthma <input type="checkbox"/> Pneumonia <input type="checkbox"/> Bronchitis <input type="checkbox"/> Frequent URI <input type="checkbox"/> Other:	<input type="checkbox"/> Chest sounds clear <input type="checkbox"/> Other:	
	GI <input type="checkbox"/>	<input type="checkbox"/> Flatulence <input type="checkbox"/> Distension <input type="checkbox"/> Herniation <input type="checkbox"/> Obesity <input type="checkbox"/> Asymmetry <input type="checkbox"/> Other:	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Emesis <input type="checkbox"/> Indigestion <input type="checkbox"/> Constipation	<input type="checkbox"/> Bulimia <input type="checkbox"/> Anorexia <input type="checkbox"/> Umbilical hernia <input type="checkbox"/> Stomach pain <input type="checkbox"/> Other pain <input type="checkbox"/> Other:	<input type="checkbox"/> See Elimination <input type="checkbox"/> Bowel sounds normal x 4 quadrants <input type="checkbox"/> Other:	
	GUR <input type="checkbox"/>	<input type="checkbox"/> Discharge <input type="checkbox"/> Lesions <input type="checkbox"/> Other:	<input type="checkbox"/> Blood in urine <input type="checkbox"/> Burning	<input type="checkbox"/> Frequent UTI <input type="checkbox"/> Menstrual problems <input type="checkbox"/> Kidney problems <input type="checkbox"/> Renal failure <input type="checkbox"/> Other:	<input type="checkbox"/> See Elimination LMP <i>(date)</i> <input type="checkbox"/> NA Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No	
	INTEG <input type="checkbox"/>	<input type="checkbox"/> Bruising <input type="checkbox"/> Lesions <input type="checkbox"/> Abrasions <input type="checkbox"/> Ulcer <input type="checkbox"/> Pruritus <input type="checkbox"/> Other:	<input type="checkbox"/> Rash <input type="checkbox"/> Pale <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundice <input type="checkbox"/> Cyanosis	<input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic <input type="checkbox"/> Dehydrated <input type="checkbox"/> Oily <input type="checkbox"/> Lumps	<input type="checkbox"/> Eczema <input type="checkbox"/> Bruises easily <input type="checkbox"/> Other:	<input type="checkbox"/> See Wound Record
	MS <input type="checkbox"/>	<input type="checkbox"/> Swelling <input type="checkbox"/> Deformities <input type="checkbox"/> Weakness/Atrophy <input type="checkbox"/> Other:	<input type="checkbox"/> Limited ROM <input type="checkbox"/> Spasms <input type="checkbox"/> Amputation(s)	<input type="checkbox"/> Scoliosis <input type="checkbox"/> Pain: <input type="checkbox"/> joint <input type="checkbox"/> bone <input type="checkbox"/> soft tissue <input type="checkbox"/> Other:	<input type="checkbox"/> See Mobility Record	
	EENT <input type="checkbox"/>	<input type="checkbox"/> Deafness <input type="checkbox"/> Hoarseness <input type="checkbox"/> Blurred vision <input type="checkbox"/> Nystagmus <input type="checkbox"/> Tracheotomy <input type="checkbox"/> Other:	<input type="checkbox"/> Facial paralysis <input type="checkbox"/> Aphasia <input type="checkbox"/> Discharge <input type="checkbox"/> Conjunctivitis	<input type="checkbox"/> Hearing problems <input type="checkbox"/> Tinnitus <input type="checkbox"/> Otitis Media <input type="checkbox"/> Vision problems <input type="checkbox"/> Other:		
	ENDO <input type="checkbox"/>	<input type="checkbox"/> Exophthalmia <input type="checkbox"/> Enlarged tongue <input type="checkbox"/> Other:	<input type="checkbox"/> Glucosuria <input type="checkbox"/> Polyuria	<input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Other:		
Immunizations up to date <i>(if no, why not?)</i>		YES	NO			
Exposed to communicable disease(s) in past 3 wks <i>(specify)</i>						

DATE AND ID