REVIEW OF SYSTEMS

PLEASE CHECK ANY SYMPTOMS YOU HAVE HAD IN THE PAST 6 MONTHS:	
CONSTITUTIONAL	DERMATOLOGIC
O Fever or chills	O Psoriasis
O Weight loss	O Eczema
ENT	NEUROLOGIC
O Cough	O Numbness/Tingling
O Cold	O Stroke
O Sinus infection	O Weakness of extremity
	O Epilepsy or seizures
CARDIOVASCULAR	
O Decreased exercise tolerance	ENDOCRINE
O Heart problems	O Thyroid problems
O Valve problems	O Diabetes
O Rheumatic fever	O Steroid usage
O Take antibiotics before dental procedures	
O Abnormal heart rhythm	INFECTIOUS
O Swelling of ankles	O HIV
O Heart murmur	O TB
	O Hepatitis
PULMONARY	
O Pneumonia	HEMATOLOGIC
O Emphysema	O Hemophilia
O TB	O Blood clots--Location _____
O Shortness of breath	O Bleeding problems
O Lung problems	O Anemia
PSYCHOLOGICAL	LYMPHATICS
O Anxiety	O Enlarged lymph nodes
O Depression	O Lymphedema
O Suicide attempts	
O Drug addition	GASTROINTESTINAL/RENAL
O Alcohol abuse	O Liver problems
	O Gallstones
MUSCULOSKELETAL	O Jaundice
O Joint pain	O Constipation
O Rheumatoid arthritis	O Diarrhea
O Back pain	O Heartburn/reflux
O Difficulty walking	O Recurrent urinary tract infections