REVIEW OF SYSTEMS

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Please email completed form to: office@kentburnettdds.com

NAME_____ DATE OF BIRTH_____

General

○ Within Normal Limits

○ Reported ○ Denied	Appetite changes	○ Reported ○ Denied	Sensitivity to heat or cold
○ Reported ○ Denied	Marked weight change	○ Reported ○ Denied	Tires easily
○ Reported ○ Denied	Night sweating	○ Reported ○ Denied	Unusual weakness
○ Reported ○ Denied	Recent trauma or infections	Other:	
		○ Reported ○ Denied	_____

Head, Eyes, Ears, Nose and Throat

○ Within Normal Limits

○ Reported ○ Denied	Dizziness	○ Reported ○ Denied	Sore throat or hoarseness
○ Reported ○ Denied	Headaches	○ Reported ○ Denied	Swallowing difficulties
○ Reported ○ Denied	Nose Bleeding	○ Reported ○ Denied	Trauma
○ Reported ○ Denied	Ringing in ears	○ Reported ○ Denied	Ulcers or lumps in mouth
○ Reported ○ Denied	Sinus infections	Other:	
○ Reported ○ Denied	Sore gums or tongue	○ Reported ○ Denied	_____

Neck

○ Within Normal Limits

○ Reported ○ Denied	Neck Pain	Other:	
○ Reported ○ Denied	Stiffness	○ Reported ○ Denied	_____

Lungs

○ Within Normal Limits

○ Reported ○ Denied	Persistent cough	○ Reported ○ Denied	Wheezing
○ Reported ○ Denied	Shortness of breath	Other:	
○ Reported ○ Denied	Swelling of ankles	○ Reported ○ Denied	_____

Heart

○ Within Normal Limits

○ Reported ○ Denied	High blood pressure	Other:	
		○ Reported ○ Denied	_____

Abdomen

○ Within Normal Limits

○ Reported ○ Denied	Heart burn	Other:	
		○ Reported ○ Denied	_____

Hematologic

○ Within Normal Limits

○ Reported ○ Denied	Anemia	Other:	
○ Reported ○ Denied	Bleeding disorders	○ Reported ○ Denied	_____
○ Reported ○ Denied	Bruises easily		

Bone Joints

○ Within Normal Limits

○ Reported ○ Denied	Back Pain	○ Reported ○ Denied	Myalgia
○ Reported ○ Denied	Joint stiffness	Other:	
○ Reported ○ Denied	Muscle cramps	○ Reported ○ Denied	_____

Neurologic

○ Within Normal Limits

○ Reported ○ Denied Cephalgia

○ Reported ○ Denied Dizziness

○ Reported ○ Denied Headaches

○ Reported ○ Denied Muscle weakness or paralysis

Other:

○ Reported ○ Denied _____

Reproductive

○ Within Normal Limits

○ Reported ○ Denied Impotence

○ Reported ○ Denied Lack of sex drive

Other:

○ Reported ○ Denied _____

Other

○ Within Normal Limits

Other:

○ Reported ○ Denied _____

Other:

○ Reported ○ Denied _____

Patient Signature

Because of HIPAA federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner as required including a full report of examination findings, diagnosis and treatment program to any referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not paid by insurance. Your dental practitioner may use your health care information and may disclose such information to your insurance company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

I certify that the medical history information is complete and accurate.

X _____ DATE_____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR