TANNER CLINIC

Rheumatology Specific Review of Systems

Please indicate if you have had any of the following symptoms in the last 3 months by circling the Yes or No beside each item.

- Drenching Night sweats: YES NO
- Unexplained weight loss: YES NO
- Recurrent fevers: YES NO
- Eyes becoming painful, red, sensitive to light and difficult to see out of: YES NO
- Dry eyes: YES NO
- Dry mouth: YES NO
- Frequent dental cavities: YES NO
- Difficulty swallowing your food: YES NO
- Oral ulcers: YES NO
- Genital ulcers: YES NO
- Nasal Polyps: YES NO
- Fingers changing colors when they are cold: YES NO
- Frequent nose bleeds with large clots: YES NO
- Facial Rash: YES NO
- Photosensitive rash: YES NO
- New headaches: YES NO
- Pain in the jaw muscles immediately after starting to chew your food: YES NO
- Joint pain: YES NO
- Joint swelling: YES NO
- Morning stiffness in the joints: YES NO If yes for how many minutes?
- Muscle weakness: YES NO
- Pitting in the fingernails: YES NO
- Fingers or toes that are swollen and resemble sausages: YES NO
- Back pain that improves with exercise: YES NO
- Chronic abdominal pain: YES NO
- Blood in the urine: No: YES NO
- Blood in the stool: YES NO
- History of Psoriasis, Crohn's disease, or Ulcerative colitis: YES NO
- If female, history of miscarriages: YES NO