Community Cancer Center

Place Name
Sticker Here

REVIEW OF SYSTEMS: Please ✓ any of the items that apply to you or that you may be experiencing.

CHIEF COMPLAINT: Please explain in your own words, the reason you are here today.

_____

GENERAL HISTORY
Normal Weight:_____
❑ Recent Weight Loss
Amount:_____
❑ Recent Weight Gain
Amount:_____
❑ Loss of appetite
❑ Fatigue
❑ Weakness
❑ Fevers
❑ Chills
❑ Night sweats
❑ Sleep problems

EYES
❑ Glasses
❑ Contact Lenses
❑ Glaucoma
❑ Cataracts
❑ Double vision
❑ Change in vision
❑ Other vision problems

EARS/NOSE/THROAT
❑ Loss of hearing
❑ Hearing aid
❑ Ringing in ears
❑ Other ear problems
❑ Dentures
❑ Dental problems
❑ Frequent sore throats
❑ Hoarseness
❑ Difficulty swallowing
❑ Dry mouth
❑ Loss of taste
❑ Neck stiffness
❑ Neck pain or swelling

CARDIOVASCULAR
❑ Pacemaker
❑ Chest pain
❑ Irregular heartbeat
❑ Palpitations
❑ Hypertension
❑ Sleep sitting or propped up
❑ Short breath when lying down
❑ Fainting spells
❑ Leg pain while walking
❑ Swelling in feet
❑ Varicose veins
❑ Oxygen use at home

RESPIRATORY
❑ Shortness of breath
❑ Difficulty breathing
❑ Coughing
❑ Dry cough
❑ Coughing up sputum
❑ Coughing up blood

GASTROINTESTINAL
❑ Heartburn
❑ Nausea/upset stomach
❑ Abdominal pain
❑ Vomiting
❑ Jaundice
❑ Change in bowel habits
❑ Constipation
❑ Diarrhea
❑ Blood in stool
❑ Hemorrhoids/fissures
❑ Colonoscopy Date of Last: _____

GENITOURINARY
❑ Difficulty urinating
❑ Frequent urination
❑ Painful urination
❑ Up at night to pass urine
❑ Blood in urine
❑ Color change of urine

WOMEN ONLY
Age of Menarche ___ Age of Menopause ___
Date of last menstrual period: _____
Date of last pelvic exam: _____
Date of last pap: _____
❑ Abnormal vaginal bleeding
❑ Hot flashes
❑ Hormone therapy
❑ Currently sexually active
Is there a chance you may be pregnant?
❑ Yes ❑ No
____# of pregnancies ____# living

MEN ONLY
❑ Impotence
❑ Difficulty with erections
❑ Penile discharge
❑ Testicular mass
❑ Testicular pain

MUSCULOSKELETAL
❑ Leg cramps
❑ Painful muscles
❑ Painful joints
❑ Artificial joints
❑ Physical disabilities
❑ Gout

SKIN & BREAST
❑ Itching
❑ Blotchy
❑ Rash
❑ Scaling
❑ Sores
❑ Color changes
❑ Pain in breast
❑ Growths
❑ Lump or mass in breast or armpit
❑ Discharge or bleeding from nipple
❑ Change in nipple
❑ Nipple inversion
❑ Change in size, shape or contour of breast
❑ Mammogram Date of Last: _____

NEUROLOGICAL
❑ Headaches
❑ Tremors
❑ Memory loss
❑ Difficulty finding words
❑ Difficulty writing
❑ Difficulty thinking clearly
❑ Numbness or tingling
❑ Dizziness
❑ Loss of consciousness
❑ Seizures
❑ Coordination
❑ Unsteady gait

PSYCHIATRIC
❑ Nervousness
❑ Anxiety
❑ Depression
❑ Change in personality
❑ Relationship problems

ENDOCRINE
❑ Excessive thirst
❑ Excessive urination
❑ Thyroid problems

HEMATOLOGIC & LYMPHATIC
❑ Swollen lymph glands
❑ Excessive bruising
❑ Excessive bleeding

ALLERGY & IMMUNOLOGY
❑ Medications
❑ Latex allergies
❑ Food or non-medication allergies
❑ Tape allergies
❑ Hay Fever
❑ None

PAIN

Do you currently have any pain? ❒ Yes ❒ No If yes, where? _____

Please circle your current pain level on a scale of 0-10 (0 being no pain and 10 being the worst pain, or intolerable).

0	1	2	3	4	5	6	7	8	9	10

Do you take medication for this pain? ❒ Yes ❒ No List: _____
Is this medication effective for your pain? ❒ Yes ❒ No