

Review of Systems Form



Page | **1**

PATIENT NAME:

Please circle **Yes** or **No** for each condition listed

General

Fatigue	Υ	N
Low Energy Level	Υ	N
Fever	Υ	N
Chills	Υ	N
Pain, location:	Υ	N
Weight Gain, amount:	Υ	N
Weight Loss, amount:	Υ	N
Loss of Appetite	Υ	N

Eyes

Double Vision	Υ	N
Excessive Tearing	Υ	N
Impaired Vision	Υ	N
Redness	Υ	N
Light Sensitivity	Υ	N

Skin

Nodules	Υ	N
Rash	Υ	N
Dry Skin	Υ	N
Radiation Therapy Effect	Υ	N
Nail Changes	Υ	N

Breast

Breast Mass	Υ	N
Breast Pain	Υ	N
Nipple Discharge	Υ	N

Neurologic

Abnormal Gait	Υ	N
Confusion	Υ	N
Dizziness	Υ	N
Headache	Υ	N
Memory Loss	Υ	N
Numbness & Tingling	Υ	Ν
Paralysis	Υ	N
Seizures	Υ	N

Difficulty breathing while lying down	Υ	N
Fainting or lightheadedness	Υ	N
Chest Pain	Υ	N
Heart Racing	Υ	N
Swelling (legs or feet)	Υ	N

Respiratory

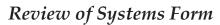
Cough	Υ	N
Coughing up Blood	Υ	N
Shortness of Breath	Υ	N
Cough with Sputum	Υ	N
Wheezing	Υ	N
Pain with Breathing	Υ	N

Ear/Nose/Throat

Lai/Nose/IIIIoat		
Earache	Υ	N
Nose Bleeds	Υ	N
Hoarseness	Υ	N
Sore Throat	Υ	N
Difficulty Swallowing	Υ	N
Mouth Sores	Υ	N
Dry Mouth	Υ	N
Altered Taste	Υ	N
Balance Issues	Υ	N
Loss of Hearing	Υ	N
Ringing in Ears	Υ	N
Congestion	Υ	N
Bleeding Gums	Υ	N

Gastroenterology

Abdominal Cramping	Υ	N
Changes in Bowel Habits	Υ	N
Constipation	Υ	N
Diarrhea	Υ	N
Dark/Black Stools	Υ	N
Nausea	Υ	N
Vomiting	Υ	N
Heartburn	Υ	N
Jaundice	Υ	N







Please circle **Yes** or **No** for each condition listed

Hematology

Prolonged Bleeding	Υ	N
Painful Lymph Nodes	Υ	N
Easy Bruising	Υ	N
Swollen Glands	Υ	Ν

Psychiatric

Anxiety	Υ	N
Depression	Υ	Ν
Insomnia	Υ	N
Poor Concentration	Υ	N
Mood Swings	Υ	N

Endocrine

Cold Intolerance	Υ	N
Heat Intolerance	Υ	Ν
Increased Sweating	Υ	N
Excessive Thirst	Υ	N

Gynecologic

Abnormal Menstrual Periods Y		N
Abnormal Vaginal Bleeding	Υ	Ν
Vaginal Discharge	Υ	N
Pelvic Pain	Υ	N
Sexual Dysfunction	Υ	N
Vaginal Dryness	Υ	N

Joint Pain	Υ	N
Joint Stiffness	Υ	N
Back Pain	Υ	N
Bone Pain	Υ	N
Muscle Pain/Weakness	Υ	N

Genitourinary _____

Burning on Urination	Υ	N
Blood in Urine	Υ	N
Increased Urination	Υ	N
Urinary Hesitancy	Υ	N

Allergy/Immunology

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Eczema	Υ	N
Frequent Infections	Υ	N
Respiratory Infections	Υ	N
Seasonal Allergies	Υ	N

Patient's Signature:	Date:
Physician's Signature:	Date:



7.

Past Medical History Form

Office Use

Page | **3**

		B/P		
NAME:		P R		
AGE:		т		
		02		
		WT HT		
If negative or doesn't apply, please write none	or NA .	<u></u>		
PAST MEDICAL HISTORY (Any condition that red	quires medication or is followe	ed by another physician)		
1	5			
2	6			
3	7			
4	High Blood Pressure:	Yes or No		
RADIATION SAFETY ISSUES: (Please circle YES or	r NO for each question listed)			
 SCLERODERMA? YES or NO (If yes, please notify your doctor as this Do you have a PACEMAKER or DEFIBRI (If yes, we will need a copy of your device) FEMALES: IS THERE A CHANCE YOU AF PAST SURGICAL HISTORY: (2 – 3 most recent su 	ILLATOR? YES or NC ice card for radiation safety por	urposes)		
1		·		
		_		
2				
3	6			
PRIOR RADIATION TREATMENT: (If YES, include When / Where)				
PRIOR CHEMOTHERAPY: (If YES, include When / Where)				
MEDICATIONS: (or PROVIDE CURRENT LIST)				
DRUG NAME	DOSE	HOW OFTEN		
1.				
2.				
3.				
4.				



Past Medical History Form



Page | 4

PHARMACY: LOCATION: **DRUG ALLERGIES:** (Please provide allergic symptoms— Rash, itching, etc.) Reaction: Reaction: Reaction: NO Latex Allergy? Reaction: **YES** or Reaction: Iodine Allergy? **YES** or NO FAMILY "CANCER" HISTORY: (Please indicate type of cancer) Father: Mother: Siblings and / or Children: Other family members: **SMOKING HISTORY:** (check appropriate box) Have you ever smoked cigarettes? ☐ Never smoked ☐ Previous smoker ☐ Current smoker If you did or now smoke cigarettes, how many packs per day?

Age started If you quit smoking, when did you quit? Do you use any other tobacco products? ALCOHOL USE: How much? How often? HAZARDOUS OCCUPATIONAL EXPOSURE: **GYNECOLOGIC/OBSTETRIC HISTORY:** (women only) Number of pregnancies: _____ Number of live births: If premenopausal, date of last period: If postmenopausal, age of menopause: _____ Did you take hormone replacement therapy after menopause? YES or NO (circle one) If yes, for how many years? _____

Signature Date \ Time