

REVIEW OF SYSTEMS

Kona Community Hospital, Radiation Oncology Clinic

NAME: _____ DOB: _____

DATE: _____

Please indicate if you have experienced any of these problems frequently or if they have worsened in the last 6 to 12 months.

GENERAL SYMPTOMS

Fevers/Chills	Y	N
Night Sweats	Y	N
Weight Loss	Y	N

EYES

New Trouble Seeing	Y	N
Double Vision	Y	N
Pain	Y	N

EAR/NOSE/MOUTH/THROAT

Pain	Y	N
Nasal Obstruction	Y	N
Bleeding from Nose	Y	N

HEART & ARTERIES

Chest Pain	Y	N
Palpitations	Y	N
Calf Pain with Walking	Y	N

LUNGS

Shortness of Breath	Y	N
Increase in Coughing	Y	N
Increase in Wheezing	Y	N
Coughing up Blood	Y	N

STOMACH & INTESTINES

Difficulty Swallowing	Y	N
Indigestion/Heartburn	Y	N
Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Change in Bowel Movements	Y	N
Blood in or Black Stool	Y	N

SKIN

Rash	Y	N
Itching	Y	N

MUSCULOSKELETAL

New Bone Pain	Y	N
Focal Weakness	Y	N
Where: _____		

GENITOURINARY

Painful Urination	Y	N
Blood in Urine	Y	N
Urinary Leakage	Y	N
Urinary Frequency	Y	N
Trouble Emptying Bladder	Y	N

MALE

Trouble Having Erection	Y	N
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FEMALE

New Blood from Vagina	Y	N
Heavy Blood from Vagina	Y	N
Last Mammogram _____		
Last Pelvic Exam _____		

BLOOD/LYMPHATICS

Easy Bruising/Bleeding	Y	N
New or Swollen Nodes	Y	N

NEUROLOGICAL

New Headaches	Y	N
Dizzy Spells	Y	N
Numbness/Weakness	Y	N

PSYCHOLOGICAL

Anxiety	Y	N
Depression	Y	N
Thoughts of Hurting Self	Y	N

PHYSICIAN SIG: _____