CARSON-TAHOE RADIATION ONCOLOGY ASSOCIATES
CURRENT REVIEW OF SYSTEMS

Name:_____ Date: _____

Please check each item "yes" or "no" as they relate to your health:

CONSTITUTIONAL:	Yes	No
Weight loss	___	___
Fatigue	___	___
Fever	___	___
EYES:		
Glasses/contacts	___	___
Double vision	___	___
Cataracts	___	___
EARS, NOSE, THROAT:		
Difficulty hearing	___	___
Ringing in ears	___	___
Vertigo	___	___
CARDIOVASCULAR:		
Chest pain	___	___
Dizziness	___	___
Shortness of breath	___	___
Difficulty lying flat	___	___
Swelling of ankles	___	___

RESPIRATORY:	Yes	No
Cough	___	___
Coughing blood	___	___
Wheezing	___	___
GASTROINTESTINAL:		
Heartburn/reflux	___	___
Nausea/vomiting	___	___
Constipation	___	___
Change in BMs	___	___
Diarrhea	___	___
Abdominal pain	___	___
Black or bloody BM	___	___
GENITOURINARY:		
Burning/frequency	___	___
Blood in urine	___	___
Erectile dysfunction	___	___
Bladder leakage	___	___

MUSCULOSKELETAL:	Yes	No
Joint pain/swelling	___	___
SKIN:		
Rash/sores	___	___
Itching/burning	___	___
NEUROLOGICAL:		
Loss of strength	___	___
Numbness	___	___
Headaches	___	___
PSYCHIATRIC:		
Anxiety/depression	___	___

Date of last colonoscopy:_____

Patient **MEDICAL** History

Diabetes	___Yes	___No
Hypertension	___Yes	___No
Cancer	___Yes	___No
Stroke	___Yes	___No
Heart Trouble	___Yes	___No
Arthritis/Gout	___Yes	___No
Depression	___Yes	___No

Patient **FAMILY** History

	Mother		Father	
	___Yes	___No	___Yes	___No
	___Yes	___No	___Yes	___No
	___Yes	___No	___Yes	___No
	___Yes	___No	___Yes	___No
	___Yes	___No	___Yes	___No
	___Yes	___No	___Yes	___No
	___Yes	___No	___Yes	___No

Allergies: _____

Patient **SOCIAL** History

Marital Status: ____Married ____Single ____Separated ____Divorced ____Widowed
Use of Alcohol: ____Yes ____No Use of Tobacco: ____Yes ____No
Use of Drugs: ____Never ____Type/Frequency_____

Medications:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Patient's Signature_____

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