

**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**

	<u>Mother</u>	<u>Father</u>
	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 \_\_\_\_\_