ALABAMA ONCOLOGY

Review of Systems

Name:_____ Date:_____ DOB: _____

Are you currently or have you experienced problems with any of the following?

1. Neurological ❑ Yes ❑ No_____
   (Weakness or numbness in arms or legs or recent seizures)
2. Appetite ❑ Yes ❑ No_____
3. Weight ❑ Yes ❑ No_____
4. Respiratory ❑ Yes ❑ No_____
5. Swelling (Where) ❑ Yes ❑ No_____
6. Nausea/Vomiting ❑ Yes ❑ No_____
7. Mouth Sores ❑ Yes ❑ No_____
8. Diarrhea ❑ Yes ❑ No_____
9. Constipation ❑ Yes ❑ No_____
10. Urinary ❑ Yes ❑ No_____
11. Fever ❑ Yes ❑ No_____
12. Pain ❑ Yes ❑ No_____
    (Location and Severity) 1 (least) - 10 (most)
13. Bleeding (Where) ❑ Yes ❑ No_____
14. Skin (Rash/Itching) ❑ Yes ❑ No_____
15. Depression ❑ Yes ❑ No_____
16. Other (describe) _____
17. Hospitalized/ER ❑ Yes ❑ No_____
    (Date and Where)
18. Loss of Sexual Potency ❑ Yes ❑ No_____
19. Date of last Menstrual Period_____ Age of First Menstrual Period_____ Number of Pregnancies_____

    Number of Live Births_____ Age at First Pregnancy_____

    Hot Flashes? ❑ Yes ❑ No Abnormal Periods? ❑ Yes ❑ No