

THOMPSON CANCER SURVIVAL CENTER AT METHODIST
 Radiation Oncology Review of Systems

Patient past and current medical history—Please circle Y or N					
Constitutional			Bladder / Kidney Problems		
Y	N	Weakness/decreased energy (1)	Y	N	Hernias
Y	N	Fever or chills	Y	N	Kidney stones
Y	N	Drenching night sweats	Y	N	Frequent daytime urination
Y	N	Pain	Y	N	Urinate frequently at night
Eye, Ear, Nose, & Throat			Y	N	Urgent urination
Y	N	Wear glasses or contacts	Y	N	Burning with urination
Y	N	Glaucoma	Y	N	Blood in your urine
Y	N	Swollen neck glands	Y	N	Trouble getting started
Y	N	Hearing loss / hearing aids	Y	N	Leakage of urine/weak stream
Y	N	Ringing in your ears	Y	N	frequent urinary infections
Y	N	Do you wear dentures?			
Y	N	Sores in mouth (2)	Sexual/Reproductive		
Y	N	Changes in smell (1)	Y	N	Sexually transmitted disease
Y	N	Change in taste of food (1)	Y	N	Male – able to get an erection
Y	N	Problems with teeth (1)	Y	N	Able to maintain erection
Y	N	Problems chewing (1)***	Y	N	Lumps in testicles
Y	N	Pain in mouth, throat, or stomach when eating (1 ea.)***	Y	N	Female – still having periods
Y	N	Difficult or painful swallowing (2)***	Y	N	How many pregnancies have you had?
Y	N	Problems with speech/voice	Y	N	How many children have you had?
			Y	N	Have you gone through menopause?
			Y	N	Bleeding after menopause
Heart / Circulation Problems			Y	N	Did you breast feed
Y	N	Chest pain or discomfort	Y	N	Take estrogen
Y	N	Irregular heart beat	Y	N	Ever taken birth control pills
Y	N	Heart murmur	Y	N	Pain with intercourse
Breathing Problems			Skin/Skeletal Problems		
Y	N	Cough	Y	N	Arthritis/ joint pain
Y	N	Coughing up blood	Y	N	Lumps
Y	N	Asthma/ wheezing	Y	N	Skin cancers
Y	N	Trouble breathing	Y	N	Use a cane or wheelchair
Y	N	Shortness of breath	Y	N	Have difficulty moving arms, legs, neck, or back*
Y	N	Unable to breathe lying down			
Nutrition					
Y	N	Only able to eat soft foods (1)***			
Y	N	Only able to drink liquids (2)***			
Y	N	Take nutritional supplements (Ensure, Boost) (1)	Nervous System		
Y	N	On a tube feeding (6)	Y	N	Memory problems**
Y	N	On nutrition by vein (TPN) (6)	Y	N	Seizures or tremors
Y	N	Wt.loss >10 lbs in 1 month (6)	Y	N	Nervousness/ anxiety
Y	N	Wt.loss >20 lbs in 6 months (6)	Y	N	Depression (1)
Y	N	Dry mouth or thick saliva (1 /1)***			
Y	N	My food intake is less than usual (1)			
Stomach and Colon			Other		
Y	N	Feeling full quickly (1)	Y	N	Financial problems (1)
Y	N	Indigestion (1)	Y	N	Chemo during radiation (3)
Y	N	Change in appetite (2)	Y	N	My activity is less than usual (1)
Y	N	Nausea/vomiting (1 / 2)	Y	N	I spend ½ day in bed or chair (2)
Y	N	Black or bright red blood in stools			
Y	N	Change in color or size of stools			
Y	N	Vomited blood			
Y	N	Constipation or diarrhea (0 / 2)			
Y	N	Problem with bowel control (2)			
					Total Score:

Completed by: _____ Nurse review: _____ Date: _____ Doctor Review: _____ Date: _____

