Name_____ DOB:_____

Do you CURRENTLY have? (IF YES, CHECK APPROPRIATE BOXES)

GENERAL
○ Fatigue
○ Fever
○ Weight Gain > 10 pounds
○ Weight Loss > 10 pounds

SKIN
○ Abnormal Moles
○ Family History of Skin Cancer
○ Nail Changes
○ New Lesions
○ Personal History of Skin Cancer
○ Personal History of Sunburns
○ Rash

HEENT
○ Double Vision
○ Eye Pain
○ Eye Redness
○ Decreased Hearing
○ Earache
○ Ear Ringing
○ Nose Bleeds
○ Dry Mouth
○ Hoarseness
○ Oral Ulcers
○ Sore Throat

NECK
○ Neck Pain
○ Swollen Glands

HEMATOLOGY
○ Easy Bruising
○ Enlarged Lymph Nodes
○ Personal History of DVT/PE
○ Prolonged Bleeding

RESPIRATORY
○ Chronic Cough
○ Decreased Exercise Tolerance
○ Difficulty Breathing
○ Sputum Production
○Coughing Up Blood
○Wheezing

BREAST
○ Breast Mass
○ Breast Pain
○ Nipple Discharge
○ Skin Changes

CARDIOVASCULAR
○ Chest Pain
○ Leg Pains with Walking
○ Leg Swelling
○ Night Awakening due to trouble Breathing
○ Palpitations
○ Shortness of Breath
○ History of Heart Attack
○ Blood Thinners
○ Cardiac Stents

GASTROINTESTINAL
○ Abdominal Pain
○ Change in Bowel Habits
○ Constipation
○ Diarrhea
○ Nausea
○ Vomiting
○ Rectal Bleeding
○ Trouble Swallowing

ENDOCRINE
○ Appetite Changes
○ Cold Intolerance
○ Increased Thirst
○Increased Urination
○ Hair Changes
○ Sexual Dysfunction

GENITOURINARY
○ Menstrual Irregularities
○ Difficulty Starting/ Stopping Urinary Stream
○ Painful Urination
○ Change in Urinary Stream
○ Increased Frequency
○ Blood in Urine
○ Urinary Retention
○ Impotence
○ Testicular Mass
○ Testicular Pain

MUSCULOSKELETAL
○ Decreased Range of Motion
○ Joint Pain
○ Joint Redness
○ Joint Swelling
○ Joint Stiffness
○ Muscle Wasting
○ Muscle Weakness
○ Muscle Aches/ Pains

NEUROLOGICAL
○ Loss of Bowel Control
○ Dizziness/ Vertigo
○ Headaches
○ Numbness/ Tingling
○ Passing Out
○ Seizures
○ Tremor

PSYCHIATRIC
○ Anxiety
○ Change in Sleep Pattern
○ Depression
○ Hallucinations
○ Suicidal Thoughts

Physician Signature_____ Date_____