Gynecologic Oncology Review of Systems

Name: ________________________________ Date: ____________

Please check (x) if any of the following apply to you now, in the past, or never.				
1.Constitutional	Currently	Past	None	Notes
Weight loss	☐	☐	☐	
Weight gain	☐	☐	☐	
Fever	☐	☐	☐	
Fatigue	☐	☐	☐	
2. Eyes				
Glasses/Contacts	☐	☐	☐	
Double vision	☐	☐	☐	
Vision Changes	☐	☐	☐	
3. ENT/Mouth				
Ringing in ears	☐	☐	☐	
Mouth sores	☐	☐	☐	
Dental problems	☐	☐	☐	
4. Cardiovascular				
Chest pain	☐	☐	☐	
Difficult breathing on exertion	☐	☐	☐	
Swelling of legs	☐	☐	☐	
Palpitations of heart	☐	☐	☐	
5. Respiratory				
Wheezing	☐	☐	☐	
Spitting up blood	☐	☐	☐	
Shortness of breath	☐	☐	☐	
Cough, chronic	☐	☐	☐	
6. Gastrointestinal				
Pain	☐	☐	☐	
Diarrhea, frequent	☐	☐	☐	
Bloody stool	☐	☐	☐	
Nausea/vomiting	☐	☐	☐	
Constipation	☐	☐	☐	
7. Genitourinary				
Blood in urine	☐	☐	☐	
Pain w/urination	☐	☐	☐	
Urgency	☐	☐	☐	
Frequency of urination	☐	☐	☐	
Incomplete emptying	☐	☐	☐	
Incontinence	☐	☐	☐	
Painful intercourse	☐	☐	☐	
Bleeding after intercourse	☐	☐	☐	

8. Musculoskeletal	Currently	Past	None	
Muscle weakness	☐	☐	☐	
Joint pain	☐	☐	☐	
9. Skin/Breast				
Pain in breast	☐	☐	☐	
Discharge	☐	☐	☐	
Masses	☐	☐	☐	
Rash	☐	☐	☐	
Ulcers	☐	☐	☐	
10. Neurological				
Headaches	☐	☐	☐	
Dizziness	☐	☐	☐	
Seizures	☐	☐	☐	
Numbness	☐	☐	☐	
Trouble walking	☐	☐	☐	
11. Psychiatric				
Depression	☐	☐	☐	
Crying, frequent	☐	☐	☐	
12. Endocrine				
Diabetes	☐	☐	☐	
Hypothyroidism	☐	☐	☐	
Hyperthyroidism	☐	☐	☐	
Hot flashes	☐	☐	☐	
13. Hematologic/Lymphatic				
Bruises, frequent	☐	☐	☐	
Cuts do not stop bleeding	☐	☐	☐	
Enlarged lymph nodes	☐	☐	☐	

	Yes	No
Do you have a living will?	☐	☐
Have you had your flu shot this year?	☐	☐
Have you had your pneumonia vaccine?	☐	☐

Family Cancer History

	Type of Cancer	Age at Diagnosis	Living or Deceased
Mother			
Father			
Siblings			
Children			
Other			

Reviewed initially by & date: ________________________

Initials for re-review & date: ____