Gainesville GYN Oncology – Review of Systems

Please check (√) if any of the following currently apply:	Notes
CONSTITUTIONAL: Weight loss ( ) Weight gain ( ) Fever ( ) Fatigue ( )	
ALLERGIES/IMMUNO: Please list allergies including Iodine/Latex in note section: Immune Disorders ( )	
EYES/ENT/MOUTH: Vision Changes ( ) Ringing in ears ( ) Current dental issues ( )	
CARDIOVASCULAR: Chest pain ( ) Difficulty breathing on exertion ( ) Leg swelling ( ) Heart palpitations ( )	
RESPIRATORY: Wheezing ( ) Chronic cough ( ) Shortness of breath ( ) Spitting up blood ( )	
GASTROINTESTINAL: Abdominal Pain ( ) Diarrhea ( ) Constipation ( ) Nausea ( ) Vomiting ( ) Last colonoscopy date: _ _ / _ _ / _ _ _ _	
GENITOURINARY: Blood in urine ( ) Pain w/urination ( ) Urgency ( ) Frequency ( ) Incomplete emptying ( ) Incontinence ( ) Painful intercourse ( ) Bleeding after intercourse ( ) Vaginal bleeding ( ) Vaginal Discharge ( ) Vulvar Itching ( ) Vulvar Burning ( ) Vulvar Lesions ( )	
MUSCULOSKELETAL: Muscle weakness ( ) Joint pain ( )	
BREAST: Breast pain ( ) Nipple discharge ( ) Lump or mass ( ) Last mammogram date: _ _ / _ _ / _ _ _ _	
NEUROLOGICAL: Headaches ( ) Dizziness ( ) Seizures ( ) Numbness ( ) Trouble walking ( )	
PSYCHIATRIC: Anxiety ( ) Depression ( ) Frequent Crying ( )	
MENOPAUSAL SYMPTOMS: Hot flashes ( ) Mood swings ( ) Insomnia ( )	
HEMATOLOGIC/LYMPHATIC: Frequent bruising ( ) Cuts that don't stop bleeding ( ) Enlarged lymph nodes ( ) Currently on Blood Thinner _____	

Relative	Type of Cancer	Age @ Diagnosis	Living or Deceased
Mother			
Father			
Sister			
Brother			
Grandparents			
Other Relatives			

Name:	**Date:** **Reviewed:**