CANCER CENTER AT GAITHERSBURG

Report of Medical History and Review of Systems

This information is for official and medically confidential use only and will not be released to unauthorized people.

Name:	Date:	
Drug Allergies:		
Current Medications and Doses:		
Hospitalizations & Surgeries: 1. 2. 3. 4.		
Previous radiation therapy?	○ Yes	○ No
Previous chemotherapy?	○ Yes	○ No
Are you **CURRENTLY** enrolled in hospice?	○ Yes	○ No

Have you experienced any of these symptoms in the past **PRIOR to your current symptoms or diagnosis?** ***(Check any that apply)***

General: ☐ Weight gain/loss, ☐ fevers, ☐ fatigue, ☐ weakness, ☐ moodiness, ☐ depression, ☐ anxiety.
Skin: ☐ Changes in color, ☐ eruptions, ☐ itching, ☐ easy bruising or bleeding, ☐ hair loss, or ☐ change in fingernails.
Head: ☐ Trauma, ☐ dizziness, ☐ seizures, ☐ fainting, ☐ headache.
Eyes: ☐ Color blindness, ☐ sensitivity to light, ☐ double vision, ☐ change in vision, ☐ excessive tearing, ☐ cataracts or ☐ glaucoma.
Ears: ☐ Deafness, ☐ ringing, ☐ pain, ☐ discharge, ☐ fullness in ears, ☐ recurrent infections.
Nose: ☐ Trauma, ☐ chronic nasal discharge, ☐ bleeding, ☐ smelling impairment.
Mouth and Teeth: ☐ Soreness of mouth or tongue, ☐ ulcers.
Neck/Throat: ☐ Hoarseness, ☐ voice changes, ☐ sore throat, ☐ or tonsillitis, ☐ goiter, ☐ swelling, ☐ enlarged nodes.
Breasts: ☐ Lumps, ☐ pain, ☐ nipple discharge, or ☐ painful nipples.
Respiration: ☐ Wheezing, ☐ shortness of breath, ☐ cough.
Cardiovascular: ☐ Palpations, ☐ increased heart rate, ☐ irregular rhythm, ☐ chest pain, ☐ cold extremities.
Gastrointestinal: ☐ Changes in appetite, ☐ difficulty swallowing, ☐ pain, ☐ blood in stools, ☐ bowel changes, ☐ hemorrhoids, ☐ jaundice.
Genitourinary: ☐ Painful urination, ☐ urgency, ☐ frequency, ☐ incontinency, ☐ difficulty starting or stopping stream, ☐ repeat bladder infections.
Hematopoietic: ☐ Bleeding disorders or ☐ easy bruising.
Musculoskeletal: ☐ Joint pain, ☐ aches, ☐ coldness, ☐ loss of strength, ☐ fracture, or ☐ dislocation.
Neurological: ☐ Sleep disturbances, ☐ sensory disturbances, ☐ twitching, ☐ seizures, ☐ loss of consciousness or memory

Do you currently have pain? ○ **YES** ○ **NO**

If yes, please continue form on back
If no, please sign and date on back

I. Where is the pain:
_____

II. What brings the pain on:
_____

_____

III. How long does it last: _____

IV. What relieves the pain: _____

V. What causes or increases the pain: _____

_____

Select the number that best represents your pain:

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
○	○	○	○	○	○	○	○	○	○

_____ _____
Patient Signature Date

_____
Physician Signature

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