Name: _____________________________________________               Date: _____/_____/______

Review of Systems

Have you noticed any change in your:

- Weight YES NO _______________________________
- Appetite YES NO _______________________________
- Energy Level YES NO _______________________________
- Fever YES NO _______________________________
- Headaches YES NO _______________________________
- Blurred / Double Vision YES NO _______________________________
- Earache YES NO _______________________________
- Ringing in ears YES NO _______________________________
- Hearing Loss YES NO _______________________________
- Nose Bleeds YES NO _______________________________
- Nasal Stuffiness YES NO _______________________________
- Sore Throat YES NO _______________________________
- Hoarseness YES NO _______________________________
- Dry Mouth YES NO _______________________________
- Difficulty / Pain opening your mouth YES NO _______________________________
- Difficulty / Pain Swallowing YES NO _______________________________
- Shortness of Breath YES NO _______________________________
- Blood in Sputum YES NO _______________________________
- Cough YES NO _______________________________
- Chest Pain YES NO _______________________________
- Palpitations YES NO _______________________________

Doctor’s Comments
<table>
<thead>
<tr>
<th>Symptom</th>
<th>YES</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
<td>Heartburn</td>
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<tr>
<td>Abdominal Pain / Cramps</td>
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<tr>
<td>Nausea / Vomiting</td>
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<tr>
<td>Diarrhea</td>
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<td>Constipation</td>
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<td>Blood in Stool</td>
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<tr>
<td>Blood in Urine</td>
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<tr>
<td>Breast Lumps</td>
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<tr>
<td>Nipple Discharge</td>
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<tr>
<td>Vaginal Discharge</td>
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<tr>
<td>Vaginal Bleeding</td>
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<tr>
<td>Frequent Urination</td>
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<tr>
<td>Incontinence</td>
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<tr>
<td>Burning on Urination</td>
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<tr>
<td>Difficulty / Unable to have an erection</td>
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<tr>
<td>Skin Rashes</td>
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<tr>
<td>Easy Bruising</td>
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<tr>
<td>Jaundice</td>
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<tr>
<td>Itching</td>
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<tr>
<td>Numbness / Weakness in arms or legs</td>
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<tr>
<td>“Pins &amp; Needles” sensations in arms or legs</td>
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<tr>
<td>Fatigue</td>
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<td></td>
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<tr>
<td>Muscle, Joint, Bone Pain</td>
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<tr>
<td>Seizures</td>
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<tr>
<td>Loss of Balance</td>
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<tr>
<td>Nervousness</td>
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</tr>
</tbody>
</table>
Patient Questionnaire

Depression YES NO ________________________________________
Enlarged Lymph Nodes YES NO ________________________________________

Do you have / or had:

Diabetes YES NO ________________________________________
High Blood Pressure YES NO ________________________________________
Heart Problems YES NO ________________________________________
Liver Disease YES NO ________________________________________
Kidney Problems YES NO ________________________________________
Hemorrhoids YES NO ________________________________________
Diverticulosis / Colitis YES NO ________________________________________

Past, Family, Social History:

Do you have any allergies? ________________________________________________________
Are you allergic to any medications or shell fish? ____________________________________________
If so, please list them here: ____________________________________________________________

Please list your current medications (including vitamins, aspirin, & other pain medications):
______________________________________________________________________________
______________________________________________________________________________

Have you had any surgery in the past? If so, please list them here: _________________________
__________________________________________________________________________________
__________________________________________________________________________________

Have you ever had radiotherapy?
If yes, when? ___________________________________________________________ YES NO

Have you ever had chemotherapy?
If yes, when? ___________________________________________________________ YES NO

Have any of your family members had cancer?

Mother  YES  NO Type: _______________________________________________
Father  YES  NO Type: _______________________________________________
Patient Questionnaire

Mother  YES  NO  Type: _________________________________________________
Father   YES  NO  Type: _________________________________________________

Do you / Have you ever smoked?  YES  NO
If so, on average, how many cigarettes do you smoke every day? __________________________
And for how Long?  _________________________________________________________________

Do you drink alcohol?  YES  NO
If so, on average, how many drinks do you have daily? _________________________________

Have you ever used recreational drugs?  YES  NO
If yes what kind?  ___________________________________________________________________

I have reviewed and confirmed the above patient history.

Resident Signature  MD  Attending Signature  MD

Print Resident Name / ID Code  Print Attending Name / ID Code