REVIEW OF SYSTEMS
FOR FOLLOW UP

Patient Label

DATE:____________________

PLEASE CIRCLE ANY SYMPTOMS YOU ARE EXPERIENCING TODAY

Prior radiation: Yes □ No □  Prior chemotherapy: Yes □ No □
Allergy to iodine: Yes □ No □  Pain location: _______ Scale: _______

Lab Values: When did you have labs drawn? Date:__________

Constitutional: unexplained weight loss/gain  fatigue level 1-10:__________

Sleep:  insomnia  early awakening

HEENT: sinus congestion  sore throat  ear pain  nose bleed
blurry vision  double vision  changes in hearing
hearing aids  dental condition: good ___  fair ___  poor ___

Cardiac: HTN  shortness of breath  lower extremity swelling
pacemaker

CVC: Implanted Port □  PICC □
Last flushed:_______  Condition _______

Respiratory: cough  coughing up blood  TB
chronic lung disease  asthma  home 02

GI: difficulty swallowing  nausea  vomiting  diarrhea
constipation  rectal bleeding  jaundice
loss of appetite  feeding tube

GU: difficulty starting stream  difficulty stopping stream
painful urination  excessive urination  blood in urine
urgency  incontinence
Male:  
IPSS Score ___________  Previous IPSS Score ___________

Changes in libido  enlarged breast tissue

Female:  
G _____  P _____  A _____  Onset of menarche _____________

Irregular cycles  hormone replacement therapy (estrogen)

Bleeding  dryness  itching  discharge

Breast:  
pain  swelling  discharge from nipples

Last mammogram ________________

Integumentary:  
rash  itching  jaundice  alopecia

Musculoskeletal:  
bone pain  detaching fingernails  lymphedema  joint pain

ADL:  
mobility problems  need help dressing

Neurologic:  
fainting  weakness  seizures  numbness and tingling

Immune:  
scleroderma  lupus  dermatomyositis

Hematologic:  
bruising  anemia  excessive bleeding

clotting disorders

Endocrine:  
excessive thirst  excessive urination  heat intolerance

cold intolerance

Signature:__________________________  Date:___________________________

Please verify attached medication list and make changes if needed. Thank you.

Nursing Notes:  
Fall Risk: N/ A ________  Low ________  High ________

Vitals:  
WT:  (SIM wt:  )  T:  B/P:  P:  R:  02 Sat:

Complaint:_________________________________________________________________________________________