

REVIEW OF SYSTEMS



Proton Therapy Center

Patient Name _____

Date of Birth _____

FOR OFFICE USE ONLY
AFFIX PATIENT LABEL HERE

Provide a short description of the medical condition resulting in your referral to IU Health Proton Therapy Center _____

Have you received radiation therapy? Yes No

If Yes, to what part(s) of the body? _____

Please indicate if you have experienced any of the following problems or conditions **in the past 12 months:**

<u>Constitutional</u>	<u>circle</u>	<u>Gastro intestinal</u>	<u>circle</u>
Weight loss	yes no	Nausea or vomiting	yes no
If yes, how much? _____		Blood in stool or black stool	yes no
Poor appetite	yes no	Diarrhea	yes no
Unexplained fatigue	yes no	Constipation	yes no
Fever, chills, sweats	yes no	Pain with bowel movements	yes no
<u>Skin</u>		Abdominal pain	yes no
Palpable lumps or bumps	yes no	Abdominal swelling	yes no
Sores that would not heal	yes no	Yellow skin or eyes	yes no
Excessive itching	yes no	<u>Genital/Urinary</u>	
Dark pigmented spots on skin	yes no	Pain with urination	yes no
Serious skin burns	yes no	Uncontrolled loss of urine	yes no
<u>Ears/Nose/Throat</u>		Little warning prior to urination	yes no
Mouth Sores	yes no	Trouble starting urination	yes no
Ear Pain	yes no	Blood in urine	yes no
Dizziness	yes no	Difficulty achieving an erection	yes no
Hoarseness	yes no	Pain with sexual intercourse	yes no
Sore Throat	yes no	Pelvic pain	yes no
Trouble swallowing	yes no	Vaginal discharge	yes no
Neck swelling or pain	yes no	<u>Musculoskeletal</u>	
<u>Breast</u>		Back Pain	yes no
Lumps in breasts	yes no	Bone pain	yes no
Pain in breasts	yes no	<u>Neurological</u>	
Nipple changes or discharge	yes no	Headaches	yes no
<u>Respiratory</u>		Double vision	yes no
Cough	yes no	Seizure	yes no
Cough producing blood	yes no	Numbness on skin or mouth	yes no
Shortness of breath	yes no	Tingling	yes no
Wheezing	yes no	Shooting pains	yes no
Chest pain	yes no	Weakness	yes no
Bronchitis or pneumonia	yes no	Uncontrolled loss of stool	yes no
<u>Cardiovascular</u>		Clumsiness	yes no
High blood pressure	yes no	Fainting	yes no
Leg or arm swelling	yes no	Unusual behavioral changes	yes no
Leg or arm pain	yes no	Memory or intellectual	yes no
		Unusual emotional changes	yes no

Female Patients ONLY

Is there any chance you could currently be pregnant?

Yes No

Have you had a tubal ligation or hysterectomy which prevents pregnancy? Yes No

Are you post-menopausal?

Yes No

If yes, by how many years? _____



SOCIAL HISTORY (Adult Patients ONLY)	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Spouse's Name
Current Occupation Retired Employee of : _____	Alcohol Consumption <input type="checkbox"/> Yes Number of drinks per day _____ <input type="checkbox"/> No <input type="checkbox"/> Quit Date _____
Tobacco Use <input type="checkbox"/> Yes Number of packs per day _____ <input type="checkbox"/> No <input type="checkbox"/> Quit Date _____ Exposure to second hand smoke <input type="checkbox"/> Yes <input type="checkbox"/> No	Caffeine Use <input type="checkbox"/> Yes Number of drinks per day _____ <input type="checkbox"/> No <input type="checkbox"/> Quit Date _____
Regular Exercise <input type="checkbox"/> Yes <input type="checkbox"/> No	Religious Preference

SOCIAL HISTORY (Pediatric Patients ONLY)	
Parents' Names	Siblings' Names and Ages
Child Lives With <input type="checkbox"/> Both parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____	Interests and Hobbies
Tobacco Use <input type="checkbox"/> Yes Number of packs per day _____ <input type="checkbox"/> No <input type="checkbox"/> Quit Date _____ Exposure to second hand smoke <input type="checkbox"/> Yes <input type="checkbox"/> No	Caffeine Use <input type="checkbox"/> Yes Number of drinks per day _____ <input type="checkbox"/> No <input type="checkbox"/> Quit Date _____
Regular Exercise <input type="checkbox"/> Yes <input type="checkbox"/> No	Religious Preference

MEDICAL HISTORY																	
Other Medical Problems	Surgeries																
Allergies	Do you have a living will? <input type="checkbox"/> Yes <input type="checkbox"/> No																
<table border="0"> <thead> <tr> <th colspan="2">Familial Mortality</th> </tr> </thead> <tbody> <tr> <td>Mother</td> <td>Age at Death _____ Cause of Death _____</td> </tr> <tr> <td>Father</td> <td>Age at Death _____ Cause of Death _____</td> </tr> </tbody> </table>	Familial Mortality		Mother	Age at Death _____ Cause of Death _____	Father	Age at Death _____ Cause of Death _____	<table border="0"> <thead> <tr> <th colspan="2">Family History of Cancer</th> </tr> <tr> <th>Relationship</th> <th>Type of Cancer</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Family History of Cancer		Relationship	Type of Cancer	_____	_____	_____	_____	_____	_____
Familial Mortality																	
Mother	Age at Death _____ Cause of Death _____																
Father	Age at Death _____ Cause of Death _____																
Family History of Cancer																	
Relationship	Type of Cancer																
_____	_____																
_____	_____																
_____	_____																
Birth History (Pediatric Patients ONLY) <input type="checkbox"/> Vaginal Birth <input type="checkbox"/> C- Section <input type="checkbox"/> Term Pregnancy OR Number of Weeks _____ Birth Weight _____ Immunizations up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No																	

