CANCER CARE OF WESTERN NEW YORK
Review of Symptoms

PATIENT NAME:______________________________ DOB: __________ Date: __________

Do you currently have any problems related to the following symptoms? Circle Yes or No

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other ____________		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other ____________		

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Short of breath	Y	N
Other ____________		

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numb/tingling	Y	N
Other ____________		

Allergies/Immunologic

Hay Fever	Y	N
Drug allergies	Y	N
Other ____________		

Ears/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N
Other ____________		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other ____________		

Integumentary

Skin rash	Y	N
Persistent itch	Y	N
Infections	Y	N
Other ____________		

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Lymph node enlargement	Y	N
Other ____________		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other ____________		

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Other ____________		

Genitourinary

Burning w/ urination	Y	N
Weak stream	Y	N
Get up at night	Y	N
Daytime frequency	Y	N
Retention of urine	Y	N
Kidney stone pains	Y	N
Erection problems	Y	N
Other ____________		

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other ____________		

This form has been completed by the patient. Date __________