Fitzgibbon Hospital
Community Cancer Center

Current Medicines and Symptoms

Name: ______________________ **Date of Birth:** ______________

What would you like to talk to the doctor about today? ______________________

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MEDICATION

Are you currently taking any prescription and/or non-prescription medications including vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives, and cold medications?

☐ No ☐ Yes ⇨ List medications below or attach your own list.

Name of Medication	Dose	How Often Taken

ALLERGIES

Have you had hives, skin rash, breathing problems or other allergic reactions to medications?

☐ No ☐ Yes ⇨ List below

Name of Medication	Describe Allergic Reaction

Have you had an allergic reaction to:

Iodine or x-ray contrast dye	☐No	☐Yes
Latex or rubber	☐No	☐Yes
Bee or wasp stings	☐No	☐Yes
Adhesive tape	☐No	☐Yes

Are there medications, other than those you are allergic to, you would prefer not to take due to prior unpleasant side affects?

☐ No ☐ Yes ⇨ ______________________

List any food allergies: ______________________ ☐ None

Name:________________________ Date of Birth:______________

SYSTEMS REVIEW

Indicate whether you have experienced the following symptoms during recent months, unless otherwise specified, by checking (✓) "NO" or "YES" for each question. Circle the symptom(s) you have experienced when multiple symptoms are listed in a question.

	NO	YES
Skin rash, sore, excessive bruising or change of a mole?	❒	❒
Excessive thirst or urination?	❒	❒
Change in sexual drive or performance?	❒	❒
Significant headaches, seizures, slurred speech or difficulty moving an arm or leg?	❒	❒
Eye problems such as double or blurred vision, cataracts or glaucoma?	❒	❒
Diminished hearing, dizziness, hoarseness or sinus problems?	❒	❒
Do you wear dentures?	❒	❒
If YES: ❒ Full ❒ Upper ❒ Lower ❒ Partial		
Bothered with cough, shortness of breath, wheezing or asthma?	❒	❒
Coughing up sputum or blood?	❒	❒
Exposed to anyone with tuberculosis?	❒	❒
"Blacked out" or lost consciousness?	❒	❒
Chest pain or pressure, rapid or irregular heartbeats, or known difficulty with a heart valve?	❒	❒
Awakening at night with shortness of breath?	❒	❒
Abnormal swelling in the legs or feet?	❒	❒
Pain in the calves of your legs when you walk?	❒	❒
Difficulty with swallowing, heartburn, nausea, vomiting, or stomach trouble?	❒	❒
Significant problems with constipation, diarrhea, blood/changes in bowel movements?	❒	❒
Approximate date of your last colon or rectum x-ray or instrument examination: protoscopy, sigmoidoscopy, colonoscopy? Date:____________ ❒ Never		
Difficulty starting your urinary stream, completely emptying your bladder or leaking urine from your bladder?	❒	❒
Burning or pain when urinating?	❒	❒
Pain, stiffness or swelling in your back, joints or muscles?	❒	❒
Fever within the last month?	❒	❒
Enlarged glands (lymph nodes)?	❒	❒
Feel you are at risk for HIV or AIDS?	❒	❒
Have you had any exposure to hazardous materials?	❒	❒
Experiencing an unusually stressful situation?	❒	❒
Weight gain or loss of more than 10 pounds during the last 6 months?	❒	❒
Problems falling asleep, staying asleep, sleep apnea or disruptive snoring?	❒	❒
Abnormal nipple discharge or a breast lump?	❒	❒
Have you ever felt a need to cut down on your alcohol consumption?	❒	❒
Do relatives/friends worry or complain about your alcohol consumption?	❒	❒
Have you been physically, sexually, or emotionally abused?	❒	❒
Have you ever received the pneumonia vaccine (pneumovax)? ❒ Unknown	❒	❒
Year ______		
Have you received a Tetanus/Diphtheria shot within the last 10 years? ❒ Unknown	❒	❒
Year ______		
Did you receive a flu shot last fall?	❒	❒