(Patient Sticker)

Cayuga MEDICAL CENTER

A Member of Cayuga Health System

MEDICAL REVIEW FORM

EMail Address: _____

Welcome to the Radiation Oncology Department. Please take a moment to help us better understand your present medical information. Kindly place a check next to each condition that pertains to you. Please elaborate when you speak with your clinical team.

General Condition
- Fatigue ☐
- Fever/Night Sweats ☐
- Chills ☐
- Weight Change ☐
- Other: _____

Head & Throat
- Vision Changes ☐
- Difficulty Swallowing ☐
- Ear Pain ☐
- Nose Bleeds ☐
- Sore Throat ☐
- Problems with Hearing ☐
- Dry Mouth ☐
- Mouth Sores ☐
- Sinus Infections ☐
- Altered Taste ☐
- Tinnitus ☐
- Other: _____

Neck
- Neck Masses ☐
- Muscle Weakness ☐
- Neck Pain ☐
- Decreased Range of Motion ☐
- Swelling in Neck ☐
- Other: _____

Skin
- Hair Loss ☐
- Bruises ☐
- Dry Skin ☐
- Nail Changes ☐
- Itching ☐
- Rash ☐
- Other: _____

Breast
- Breast Mass ☐
- Nipple Discharge ☐
- Breast Pain ☐
- Other: _____

Heart
- Irregular Rhythm ☐
- Chest Pain ☐
- Swelling of Legs ☐
- Palpitations ☐
- Other: _____

Respiratory
- Cough ☐
- Shortness of Breath ☐
- Coughing up Blood ☐
- Wheezing ☐
- Other: _____

Gastrointestinal
- Abdominal Pain ☐
- Change in Bowel Habits ☐
- Heartburn ☐
- Nausea/Vomiting ☐
- Rectal Bleeding ☐
- Hemorrhoids ☐
- Other: _____

Genitourinary
- Burning on Urination ☐
- Frequency of Urination ☐
- Blood in Urine ☐
- Incontinence ☐
- Kidney Stones ☐
- Problems w/Sexual Function ☐
- Vaginal Discharge ☐
- Other: _____

Musculoskeletal
- Arthritis ☐
- Bone Pain ☐
- Joint Pain ☐
- Weakness ☐
- Other: _____

Neurologic
- Confusion ☐
- Dizziness ☐
- Headache ☐
- Insomnia ☐
- Memory Loss ☐
- Seizure ☐
- Stroke ☐
- Other: _____

Emotional
- Mood Swings ☐
- Depression ☐
- Hallucinations ☐
- Other: _____

Endocrine
- Diabetes ☐
- Hot Flashes ☐
- Thyroid Problems ☐
- Other: _____

Allergies	Yes	No
Latex	☐	☐
Iodine	☐	☐
IV Dye	☐	☐
Seafood	☐	☐
Food Items	☐	☐

Drug Allergies: List ☐ None

_____
_____
_____
_____

Medications: List ☐ None

_____
_____
_____
_____
_____
_____

Patient Signature: _____ Date: _____ Time: _____

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