CULICCHIA
NEUROLOGICAL CLINIC
Complete Neuro-Care for the Gulf South

Neuro-Oncology Review of Systems

Are you currently on chemotherapy? ☐ **Yes** ☐ **No**

If yes, what were the last dates that you had chemotherapy? **By mouth:** _____

By vein: _____

Do you use a medication to thin your blood? ☐ **Yes** ☐ **No**

If yes, what medication? _____

Do you take aspirin every day? ☐ **Yes** ☐ **No**

Have you had any hospitalizations or visits to the emergency department since your last visit?

☐**Yes** ☐**No**

If yes, what day(s): _____

What was the reason for your emergency department visit and/or hospitalization? _____

_____

_____

_____

Please place a check in front of (or circle) any of the following symptoms that you had in the months leading up to your first visit with us, or that you've had in the time since we've last seen you. If you have not had any symptoms in the category, please place a check in front of (or circle) "No problems".

Review of Systems

Constitutional: ☐Fever ☐Chills ☐Sweats/Night Sweats ☐Generalized Weakness ☐Fatigue ☐Recent unexpected weight loss ☐Recent unexpected weight gain ☐Decreased appetite ☐Excessive thirst ☐Heat intolerance ☐Cold intolerance ☐Excessive thirst **☐No Problems**

Glands/Lymph nodes: ☐Lumps in the neck ☐Swollen glands in the neck ☐Swollen glands near the collarbone/in the upper chest ☐Swollen glands in the armpit ☐Swollen glands in the groin/inner thigh **☐No Problems**

Skin: ☐Itching ☐Rash ☐Mole change ☐Open sores that won't heal ☐Dry skin ☐Flaky skin ☐Skin discoloration **☐No Problems**

Eyes: ☐Blurred vision ☐Double vision ☐Loss of vision in one eye (☐Right ☐Left) ☐Loss of part of the visual field in one eye (☐Right ☐Left) ☐Loss of part of the visual field in both eyes ☐Yellowing of the whites of the eyes **☐No Problems**

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Ears: ☐New difficulty hearing ☐Worsening of pre-existing hearing difficulty ☐Ringing/buzzing in the ears (tinnitus) ☐Ear pain (☐Right ☐Left ☐Both) ☐Drainage from the ear(s) (☐Right ☐Left ☐Both) ☐Dizziness ☐Vertigo ☐Unsteadiness (disequilibrium) ☐Balance difficulties **☐No Problems**

Nose: ☐Stuffy nose ☐Frequent colds ☐Hay fever ☐Sinus trouble ☐Frequent nosebleeds **☐No Problems**

Mouth and Throat: ☐Frequent sore throats ☐Pain near teeth or mouth ☐Sores in the mouth ☐Hoarseness/Voice change ☐Neck pain ☐Difficulty swallowing (☐Solids ☐Liquids ☐Pills/Medications) **☐No Problems**

Chest (lungs and heart): ☐Chest pain ☐Cough (Are you "bringing anything up" with the cough? ☐Yes ☐No; If yes, is it? ☐Clear/whitish ☐Green/yellow ☐Bloody ☐"Rusty" colored ☐Foul smelling ☐Other:_____) ☐Shortness of breath (Do you/did you experience this: ☐with activity only ☐with activity, and at rest ☐suddenly while at rest ☐lying down only ☐randomly) ☐Wheezing ☐Palpitations/heart beating out of rhythm ☐Heart beating too fast ☐Pain in the ribs/chest/side when taking a breath **☐No Problems**

Gastrointestinal (GI): ☐Heartburn/Acid Reflux ☐Ulcers ☐Abdominal pain ☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation ☐Loss of bowel control ☐Blood in stool ☐Black/"tarry" stool ☐Hemorrhoids ☐Pale/"clay" colored stool ☐Jaundice/yellow skin **☐No Problems**

Genitourinary (GU): ☐Frequent/increased frequency of urination ☐"Excessive" urination ☐Urinary urgency ☐Increased urination at night ☐Difficulty initiating urination ☐Decrease "strength" of urine stream ☐Painful urination ☐Blood in the urine ☐Loss of bladder control **☐No Problems**

Musculoskeletal: ☐Joint pain ☐Joint stiffness ☐Muscle pain ☐Muscle stiffness ☐Muscle weakness ☐Back pain ☐Swelling in one foot (☐Right ☐Left) ☐Pain in one foot (☐Right ☐Left) ☐Swelling in one leg (☐Right ☐Left) ☐Swelling in both legs ☐Leg pain (☐Right ☐Left ☐Both) ☐Pain behind the knee (☐Right ☐Left ☐Both) ☐Pain and/or swelling associated with red/painful skin ☐Pain and/or swelling associated with change in skin temperature (☐Warm to touch ☐Cool to touch) **☐No Problems**

Male Reproductive: ☐Sexual dysfunction ☐Difficulty achieving or maintaining erections ☐Difficulty ejaculating ☐Testicular pain ☐Testicular swelling **☐No Problems**

Female Reproductive: ☐Sexual Dysfunction ☐Painful intercourse ☐Vaginal dryness ☐Pelvic pain ☐Loss of menses/period ☐Abnormal bleeding **☐No Problems**

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Emotional: ☐Anxiety/nervousness ☐Increased pre-existing anxiety/nervousness ☐Depression ☐Worsened pre-existing depression ☐Irritability ☐Increased pre-existing irritability ☐Personality changes ☐Mood swings ☐Difficulty falling asleep ☐Difficulty staying asleep (Average hours of sleep per night: ___hrs Bedtime ___:___ AM/PM Wake time ___:___ AM/PM) ☐Suicidal thoughts ☐Homicidal thoughts **☐No Problems**

Hematologic: ☐Easy bruising ☐Easy bleeding ☐Frequent/re-occurring infections **☐No Problems**

Allergies: ☐Hay fever/environmental allergies ☐Dust sensitivity ☐Mold allergies ☐Food sensitivity ☐Food intolerance ☐New medication allergies ☐New chemical sensitivity **☐No Problems**

Thought Processes: ☐Changes in memory ☐Changes in concentration ☐Difficulty coming up with words you want to say ☐Difficulty understanding what others are saying to you **☐No Problems**

Nerves of the face and head: ☐Face numbness ☐Change in facial appearance **☐No Problems**

Strength: ☐Weakness in one hand/arm, foot/leg (☐Right ☐Left) ☐Weakness in one whole side of the body (☐Right ☐Left) ☐Weakness in both arms ☐Weakness in both legs ☐Difficulty climbing stairs ☐Difficulty getting out of chairs ☐Difficulty reaching above your head **☐No Problems**

Sensation: ☐Burning ☐Aching ☐Tingling ☐Numbness ☐Decreased sensation ☐Experience pain sensation with something that shouldn't be painful If you answered yes to any of these questions, please indicated body part(s) and side of the body affected: _____

_____

☐No Problems

Coordination: ☐Change in coordination ☐Reaching out and knocking things over ☐Difficulty with tasks requiring manual dexterity (such as buttoning buttons or using utensils to eat) ☐Difficulty walking ☐Bumping into doorways ☐Bumping into furniture ☐Falls (How many? ___)

☐No Problems

Headaches: Do you have headaches? ☐Yes ☐No If yes, are they: ☐Brief ☐Long lasting ☐Worse when lying down ☐Worse when standing up ☐Worse if bearing down (such as when lifting something, bending over, or when having a bowel movement)

☐No Problems

Seizures: Have you ever had a seizure? ☐Yes ☐No
If yes, did you lose consciousness with the seizure? ☐Yes ☐No
How often do you have seizures?_____
When was the last time you had a seizure? _____

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Do you experience: ☐Butterflies in your stomach (like being on a rollercoaster) ☐Unexpected foul smells (especially burning rubber or burning metal) ☐Feelings of déjà vu (unexpected familiarity with a situation, place, or events) ☐Involuntary movements of face, arms, hands, legs, other body parts ☐Staring spells Have you ever awakened to find that you had bitten your tongue or lost control of your bowel or bladder? ☐Yes ☐No **☐No Problems**

Other: ☐"Electric shocks" in the neck when looking down ☐Sudden sharp pain (If yes, location: ☐neck ☐back ☐shoulders ☐arms ☐hips ☐legs) ☐Pain, numbness, or other sensory change that starts in the middle of your back and travels around to the middle of your front in a "band-like" fashion **☐No Problems**

_____ ___/___/_____

Printed name of person who completed this form **Date (mm/dd/yyyy)**