

The Breast Surgeons at the Helen F. Graham Cancer Center

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Name _____ DOB _____

General	<input type="checkbox"/> Poor appetite <input type="checkbox"/> Fever/chills <input type="checkbox"/> Weight loss <input type="checkbox"/> Weight gain <input type="checkbox"/> Faintness <input type="checkbox"/> Fatigue <input type="checkbox"/> Headaches <input type="checkbox"/> Decreased Hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Weakness <input type="checkbox"/> Hoarseness <input type="checkbox"/> Painful Swallowing <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Other: _____
Respiratory	<input type="checkbox"/> Shortness of breath/difficulty breathing: <input type="checkbox"/> at rest <input type="checkbox"/> with activity <input type="checkbox"/> when lying down <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Other: _____
Cardiovascular	<input type="checkbox"/> Chest pain/pressure at rest <input type="checkbox"/> Chest pain/pressure with activity <input type="checkbox"/> Leg cramping with activity <input type="checkbox"/> Fluid retention <input type="checkbox"/> Palpitations <input type="checkbox"/> Use of blood thinners (which one _____) <input type="checkbox"/> Other: _____
Gastrointestinal	<input type="checkbox"/> Abdominal bloating/fullness <input type="checkbox"/> Abdominal tenderness <input type="checkbox"/> Cramping <input type="checkbox"/> Belching <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Incontinence <input type="checkbox"/> Flatulence <input type="checkbox"/> Stools, black/bloody <input type="checkbox"/> Hiccoughing <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood <input type="checkbox"/> Other: _____
Genitourinary	<input type="checkbox"/> Burning <input type="checkbox"/> Frequency <input type="checkbox"/> Urgency <input type="checkbox"/> Hesitancy <input type="checkbox"/> Waking up to void at night <input type="checkbox"/> Dribbling <input type="checkbox"/> Pain <input type="checkbox"/> Incontinence <input type="checkbox"/> Blood in urine <input type="checkbox"/> Abnormal Vaginal Bleeding <input type="checkbox"/> Decreased urine output <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Kidney failure <input type="checkbox"/> Other: _____
Neuromuscular	<input type="checkbox"/> Back pain <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Joint swelling <input type="checkbox"/> Leg pain <input type="checkbox"/> Neck pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Muscle pain <input type="checkbox"/> Poor range of motion <input type="checkbox"/> Other: _____
Skin	<input type="checkbox"/> Change in skin color <input type="checkbox"/> Itching <input type="checkbox"/> Abnormal Bruising <input type="checkbox"/> Rash <input type="checkbox"/> Other: _____
Neurologic	<input type="checkbox"/> Concentration difficulties <input type="checkbox"/> Confusion / disorientation <input type="checkbox"/> Dizziness <input type="checkbox"/> Drowsiness <input type="checkbox"/> Faintness <input type="checkbox"/> Memory problems <input type="checkbox"/> Speech difficulties <input type="checkbox"/> Visual changes <input type="checkbox"/> Other: _____
Lymphatic	<input type="checkbox"/> Enlarged lymph nodes <input type="checkbox"/> Swelling of extremity <input type="checkbox"/> Heaviness of extremity <input type="checkbox"/> Tightness/hardening of skin <input type="checkbox"/> Other: _____