Lancaster Cancer Center
Care Beyond Treatment

Print Form

Patient Name: _____ **Date:** _____

Symptom Questionnaire

Constitutional

Recent weight loss	☐ No	☐ Yes
Recent weight gain	☐ No	☐ Yes
Fever / Chills	☐ No	☐ Yes
Fatigue	☐ No	☐ Yes
Night Sweats	☐ No	☐ Yes
Appetite loss	☐ No	☐ Yes

Eyes

Blurred vision	☐ No	☐ Yes
Loss of vision	☐ No	☐ Yes
Pain or redness	☐ No	☐ Yes
Double vision	☐ No	☐ Yes

Ears / Eyes / Nose / Mouth / Throat

Hearing loss	☐ No	☐ Yes
Ringing in ears	☐ No	☐ Yes
Nose bleeds	☐ No	☐ Yes
Runny nose	☐ No	☐ Yes
Sinus / Nasal Congestion	☐ No	☐ Yes
Mouth Sores	☐ No	☐ Yes
Sinus / Nasal Congestion	☐ No	☐ Yes
Mouth Sores	☐ No	☐ Yes

Cardiovascular

Chest pain	☐ No	☐ Yes
Palpitations	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes
Swelling of ankles	☐ No	☐ Yes

Respiratory

Chronic cough	☐ No	☐ Yes
Spitting up blood	☐ No	☐ Yes
Wheezing	☐ No	☐ Yes

Gastrointestinal

Difficulty swallowing	☐ No	☐ Yes
Heartburn / Indigestion	☐ No	☐ Yes
Nausea / Vomiting	☐ No	☐ Yes
Stomach Pain	☐ No	☐ Yes
Diarrhea	☐ No	☐ Yes
Constipation	☐ No	☐ Yes
Black stool	☐ No	☐ Yes
Rectal bleeding	☐ No	☐ Yes
Loss of bowel control	☐ No	☐ Yes
Change in caliber of stool	☐ No	☐ Yes

Genitourinary

Burning with urination	☐ No	☐ Yes
Blood in urine	☐ No	☐ Yes
Frequent urination	☐ No	☐ Yes
Difficulty urinating	☐ No	☐ Yes
Loss of bladder control	☐ No	☐ Yes
Night time urination	☐ No	☐ Yes

Musculoskeletal

Burning with urination	☐ No	☐ Yes
Blood in urine	☐ No	☐ Yes
Frequent urination	☐ No	☐ Yes
Difficulty urinating	☐ No	☐ Yes

Neurological

Headaches	☐ No	☐ Yes
Dizziness / lightheadedness	☐ No	☐ Yes
Numbness / tingling	☐ No	☐ Yes
Problems with balance	☐ No	☐ Yes
Seizures	☐ No	☐ Yes
Speech problems	☐ No	☐ Yes

Psychiatric

Memory loss	☐ No	☐ Yes
Confusion	☐ No	☐ Yes
Depression / feeling sad	☐ No	☐ Yes
Anxiety	☐ No	☐ Yes
Difficulty sleeping	☐ No	☐ Yes

Hematologic

Easy bruising / bleeding	☐ No	☐ Yes
Swollen glands	☐ No	☐ Yes

Skin

Rash	☐ No	☐ Yes
Itching	☐ No	☐ Yes
Burning	☐ No	☐ Yes
Tumors	☐ No	☐ Yes

Reviewed by: _____

Date: _____

Lancaster Cancer Center
Care Beyond Treatment

Patient Name: _____ **Date:** _____

MEDICATIONS

Please list all medications, including prescription, over the counter, vitamins, supplements, and herbs

Medication	Dose	# of Times Per Day
Example: Motrin	Example: 200mg	Example: 3 times a day

ALLERGIES

Please list below all drugs, foods, environmental, including latex powders, etc. that you have allergic reactions to along with the type of reaction:

Drug	Reaction	Drug	Reaction

Reviewed by: _____ Date: _____