Follow Up Form

CARO | CENTRAL ALABAMA RADIATION ONCOLOGY

NAME:	**HOME # :** **□NO CHANGE** **CELL #:** **EMAIL:**
Address: □No Change	**City/State/Zip:**

INSURANCE INFORMATION:

Primary: _____ Member ID:_____ Group: _____

Secondary:_____ Member ID:_____ Group:_____

Spouse Name:_____ Spouse DOB:_____

Spouse Employer:_____ Phone:_____

CURRENT MEDS: □NO CHANGE

PREFERRED PHARMACY: NAME: LOCATION: PHONE:

ALLERGIES: □NO CHANGE

LIST OF PHYSICIANS PRESENTLY SEEING OR HAVE SEEN SINCE LAST VISIT:

RECENT SURGERIES OR HOSPITALIZATIONS SINCE LAST VISIT:

HAVE YOU HAD ANY RECENT SCANS OR PROCEDURES DONE SINCE LAST VISIT? □ Yes □No
IF YES, LIST TYPE OF SCAN/PROCEDURE, DATE, AND FACILITY

HAVE YOU EVER HAD A COLONOSCOPY? □ Yes □No IF YES, DATE OF PROCEDURE?

DO YOU CURRENTLY SMOKE □ Yes □No IF YES, HOW MUCH PER DAY?

IF MALE, LIST DATE OF LAST PSA:

IF FEMALE, LIST DATE OF LAST MAMMOGRAM: LAST PAP SMEAR:

DO YOU HAVE A LIVING WILL? □ Yes □No

REVIEW OF SYSTEMS (symptoms within last two weeks) (circle all that apply)

Poor Appetite	Hair Loss	Bloody Vomit	Muscle Weakness
Fatigue	Increased Skin Sensitivity to Sun	Rectal Bleeding	Range of Motion
Fever	Hives/Itching/Rash	Hemorrhoids	Describe _____
Night Sweats	Breast Masses	Black Tarry Stools	Disorientation/Confusion
Weight Change	Nipple Discharge	Nausea	Dizziness
Blurred vision	Nipple Inversion	Abdominal Pain/Cramping	Difficulty Walking
Double Vision	Breast Pain	Vomiting	Headaches
Visual Difficulties	Heart Racing	Burning in Urination	Nerve Pain/Neuropathy
Difficulty Swallowing	Chest Pain	Frequent Urination	Seizure
Impaired Hearing	Swelling to feet and legs	Blood in Urine	Anxiety
Hoarseness	Cough	Impaired Sex Function/Impotent	Hallucinations
Mouth Dryness	Shortness of Breath	Loss of Bladder/Bowel	Depression
Oral Bleeding	Coughing up Blood	Waking at Night to Urinate	Diabetes
Mouth Sores	Chest Pain upon Breathing	Urine Urgency	Hot Flashes
Neck Pain	Wheezing	Vaginal Discharge/Bleeding	Thyroid Disease
Swelling in Neck	Constipation	Bone Pain	Easy Bruising
Blisters on Skin	Diarrhea	Joint Pain	Swollen Lymph Nodes

Other: _____

I attest that all of the information in this document is true, correct to the best of my knowledge, and understand that my physician will base his opinions and judgements on the same.

_____ _____

Patient Signature **Date**