Dr. Darrel L Ross, MD, DABR
317 Western Boulevard
Jacksonville, North Carolina 28546
Phone: 910.577.4900
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www.onslowradiationoncology.org

Follow up Form

Name: <Last Name>, <First Name>	Pt I.D. # <Patient Id 1>	Current Age: <Age>	Today's Date: <Current Date>
Chief complaint - Follow Up			

Patient Medical History continued (circle symptoms you are currently experiencing)		
Constitutional	☐ Normal	Lack of appetite/ fatigue/ fever/ tired/ night sweats/rigors or chills/ change in weight
Allergic/ Immunologic	☐ Normal	Allergies/ Adverse reactions
Head	☐ Normal	Alopecia
Eyes	☐ Normal	Blurred vision/ double vision/ night blindness/ light sensitivity/ glasses
ENMT	☐ Normal	Sort throat/ difficulty swallowing/ ear pain/ nose bleed/ problems w hearing/ mouth dryness/ oral bleeding/ ear pain/ sinusitis/ sputum production/ altered taste
Neck	☐ Normal	Neck masses/ muscle weakness/ neck pain/ decreased range of motion/ swelling of neck
Integumentary	☐ Normal	Blistering/ Bruising/ dry skin/ facial burning/ nail changes/ light sensitivity/ pruritus/ rash/ hives
Breasts	☐ Normal	Breast masses/ nipple discharge/ nipple inversion/ pain
Cardiovascular	☐ Normal	Irregular heart beat/ chest pain/ swelling/ difficulty breathing when lying down/ palpitations
Respiratory	☐ Normal	Cough/ difficulty breathing/ coughing up blood/ hiccoughs/ pleuritic chest pain/ wheezing
Gastrointestinal	☐ Normal	Abdominal pain/ change in bowel habits/ constipation/ diarrhea/ heartburn/ blood in vomit/ passing blood from rectum/ hemorrhoids/ bloody, dark sticky stool, nausea/ pain, cramping/ vomiting
Genitourinary (F)	☐ Normal	Painful urination/ frequency/ genital masses/ blood in urine/ incontinence/ urinating at night/ renal stone disease/ problem with sexual function/ urgency/ urine color change/ vaginal discharge, bleeding/ spotting
Genitourinary (M)	☐ Normal	Painful urination/ frequency/ genital masses/ blood in urine/ impotence/ incontinence/ urinating at night/ renal stone disease/ retrograde ejaculation/ scrotal swelling/ urgency/ urine color change
Musculoskeletal	☐ Normal	Arthritis/ bone pain/ joint pain/ muscle swelling/ decreased range of motion
Neurologic	☐ Normal	Disorientation/ Dizziness/ abnormal gait/ headaches/ insomnia/ memory loss/ motor weakness/ sensory problems/ paralysis/seizure/ stroke
Psychiatric	☐ Normal	Delusions/ hallucinations/ mood swings/ depression/ euphoria
Endocrine	☐ Normal	Diabetes/ hot flashes/ menstrual irregularities/ thyroid disease
Hematologic/ Lymphatic	☐ Normal	Easy bruising/ tender or enlarges lymph nodes

Surgeries or Procedures Since Your Last Appointment (including biopsies, hemorrhoids, cysts, etc.)				**Imaging Since Your Last Appointment (X-Rays, MRI, Mammograms, Etc.)**		
Operation	**Date**	**Surgeon**	**City/State**	**Procedure**	**Date**	**City/State**

Electronically Authenticated By: <Approved By> <Approved date time>

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Radiation Treatment/Chemotherapy Updates			
Radiation Therapy		☐ YES	☐ NO
TX Site & Date:	1.		
	2.		
	3.		
Chemotherapy		☐ YES	☐ NO
Drug & Date	1.		
	2.		
	3.		

Pacemacker/defibrilator
Do you have a PaceMaker/Defibrilator? ☐ **YES** ☐ **NO**
If yes: please present your card to the front desk staff **What is the name of the company of your device?** _____ **When was it last checked?** _____ **When will it be checked next?** _____

Females Only: LMP: _____

HORMONE/IMMUNOTHERAPY: ☐**YES**☐**NO** **DATE/NOTES:**

Please verify your medications listed below:
<Current Medications-Custom-Name and Course (Default)>

Electronically Authenticated By: <Approved By> <Approved date time>