Compass Oncology
Patient History

Name (First & Last): _____ Today's Date: _____

Date of Birth: _____ Referring Physician: _____

☐ Male ☐ Female Primary Care Physician: _____

OB/Gyn Physician: _____

Reason for Today's Visit: _____

Personal Medical History: Please check all that apply and include date of diagnosis

☐	Anemia	
☐	Arthritis	
☐	Asthma	
☐	Blood Disorder/Coagulopathy	
☐	Cancer (please list type)	
	1.	
	2.	
	3.	
☐	Diabetes	
☐	Emphysema/COPD	
☐	Epilepsy	
☐	Exposure to Asbestos	
☐	Heart Disease (e.g. Heart Attack)	
☐	Hepatitis Type:_____	

☐	High Blood Pressure	
☐	Kidney Disease	
☐	Liver Disease	
☐	Mental Illness	
☐	Migraine Headaches	
☐	Pneumonia	
☐	Sexually Transmitted Disease	
☐	Sleep Apnea	
☐	Stroke	
☐	Thyroid Disease	
☐	Tuberculosis	
☐	Ulcer	
☐		
☐		

Hospitalizations/Surgeries: Please list all hospitalizations and surgeries

	Date	Reason for Hospitalization or Type of Surgery	Where	Doctor
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Have you ever been advised to have surgery which was not performed? _____

Previous Treatment for Cancer (if applicable)

Radiation Therapy: _____

Chemotherapy: _____

Hormone Therapy: _____

Compass Oncology Patient History

Name (First & Last): _____ Date of Birth: _____

Immunizations: Please check previous immunizations received and include date of last vaccine if known

Chickenpox ☐		Hepatitis B ☐		Polio ☐	
Flu ☐		Measles ☐		Smallpox ☐	
Hemophilus (HIB) ☐		Pneumococcal ☐		Tetanus ☐	
Other: ☐					

Medications: Please list current prescriptions and over-the-counter medications, as well as herbals, supplements and vitamins.

	Medication	Dosage	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Allergies

Are you allergic to any medications? ☐ **Yes** ☐ **No**

If yes, please list the medications that you are allergic to and the type of reaction:

_____

_____

Are you allergic to:

Latex: ☐ **Yes** ☐ **No**

Tape: ☐ **Yes** ☐ **No** If yes, please list the type of tape: _____

Eggs: ☐ **Yes** ☐ **No**

Vaccines: ☐ **Yes** ☐ **No** If yes, please list the type of vaccine: _____

Other allergies: ☐ **Yes** ☐ **No**

If yes, please list other allergies:

_____

Blood Transfusions

Have you ever had a blood transfusion? ☐ **Yes** ☐ **No**

If yes, did you have a reaction? ☐ **Yes** ☐ **No**

Date of last blood transfusion: _____

Compass Oncology Patient History

Name (First & Last): _____ Date of Birth: _____

Social History

Marital Status: ☐ Single ☐ Married ☐ Domestic partner ☐ Divorced ☐ Widowed

Do you have children? ☐ **Yes** ☐ **No** If yes, how many children: _____

Occupation (previous if retired): _____ ☐ Retired

Have you served in the military? ☐ **Yes** ☐ **No** If yes, dates of service: _____

Do you have an Advance Directive? ☐ **Yes** ☐ **No**

Is there a person who you would like to be your primary contact regarding your healthcare? ☐ **Yes** ☐ **No**
If yes, Name: _____ Relationship: _____ Phone: _____

Do you currently use tobacco products:
☐ **Yes** Use per day: ☐ Cigarettes: _____ ☐ Cigars: _____ ☐ Pipe: _____ ☐ Chewing tobacco: _____
For how many years have you used the above tobacco product? _____

☐ **No** Have you ever used tobacco products in the past? ☐ **Yes** ☐ **No**
If yes, use per day: ☐ Cigarettes: _____ ☐ Cigars: _____ ☐ Pipe: _____ ☐ Chewing tobacco: _____
When did you quit? _____ For how many years did you use the above tobacco product? _____

How many servings of wine, beer or other alcoholic beverage(s) do you drink per day? _____ Per week? _____
Do you have a history of alcoholism? ☐ **Yes** ☐ **No**

Have you used illegal drugs? ☐ **Yes** ☐ **No**
If yes, which ones? _____
Do you use marijuana? ☐ **Yes** ☐ **No**

What do you do for exercise? _____ How many times per week? _____

Family History: Please include age at diagnosis

	Grandfathers		Grandmothers		Parents		Siblings		Children	
	Paternal	Maternal	Paternal	Maternal	Father	Mother	Brother	Sister	Son	Daughter
Cancer:										
Breast										
Ovarian										
Colon										
Lung										
Prostate										
Other:										
High Blood Pressure										
Heart Disease										
Stroke										
Diabetes										
Anemia/Clotting Disorder										

Compass Oncology Patient History

Name (First & Last): _____ Date of Birth: _____

Symptoms: Please check all that apply or *None*

Do you have Pain? ☐ **Yes** ☐ **No**

If yes, Where: _____ Intensity (1-10): _____ Frequency: _____

General:
- ☐ Change in appetite
- ☐ Change in weight
- ☐ Fatigue
- ☐ Generalized weakness
- ☐ Fever or chills
- ☐ Night sweats
- ☐ Frequent colds
- ☐ *None*

Eyes:
- ☐ Glasses/contacts
- ☐ Change in vision
- ☐ Eye pain
- ☐ Double vision
- ☐ *None*

Ears, nose, mouth, throat:
- ☐ Hearing problems
- ☐ Nose bleeds
- ☐ Sinus trouble
- ☐ Post nasal drip
- ☐ Dental problems
- ☐ Sore mouth, tongue or lips
- ☐ Hoarseness
- ☐ Sore throat
- ☐ Bleeding gums
- ☐ *None*

Heart:
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Murmur
- ☐ Swollen feet, ankle or hands
- ☐ *None*

Lungs:
- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Sputum or phlegm production
- ☐ Difficulty breathing when flat
- ☐ *None*

Digestive:
- ☐ Difficulty swallowing
- ☐ Frequent heartburn
- ☐ Belching or excess gas
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stools
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Hemorrhoids
- ☐ Abdominal pain
- ☐ *None*

Genitourinary:
- ☐ Pain/burning with urination
- ☐ Excessive nighttime urination
- ☐ Excessive daytime urination
- ☐ Slow starting or stopping
- ☐ Unable to hold urine
- ☐ Blood in the urine
- ☐ *None*

Men only…
- ☐ Prostate infections
- ☐ Impotence

Women only…
- ☐ Vaginal discharge or bleeding
- ☐ Painful intercourse

Bones, joints, muscles:
- ☐ Cramping
- ☐ Joint pain
- ☐ Swollen joints
- ☐ *None*

Endocrine:
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Hot flashes
- ☐ *None*

Nervous system:
- ☐ Headaches
- ☐ Dizziness or vertigo
- ☐ Fainting
- ☐ Convulsions or seizures
- ☐ Memory loss
- ☐ Poor coordination
- ☐ Weakness of arms or legs
- ☐ Numbness in arms or legs
- ☐ *None*

Immunologic:
- ☐ Severe allergic reactions
- ☐ Frequent or severe infections
- ☐ Pollen allergies/hay fever
- ☐ *None*

Skin:
- ☐ Rash, hives or itching
- ☐ Change in color
- ☐ Change in mole or wart
- ☐ A sore that won't heal
- ☐ *None*

Blood disorders:
- ☐ Easy bruising
- ☐ Abnormal bleeding
- ☐ Enlarged lymph nodes
- ☐ *None*

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Trouble sleeping/insomnia
- ☐ Work/family stress
- ☐ *None*

Compass Oncology Female and Breast Cancer Patient History

Name (First & Last): _____ Date of Birth: _____

OB/Gyn History

How many times have you been pregnant: _____ How many live births have you had: _____

Your age at the birth of your first child? _____

Any complications during pregnancy? ☐ **Yes** ☐ **No** Any history of miscarriages or abortions? _____

Did you breast feed? ☐ **Yes** ☐ **No** If yes, how long did you breast feed? _____

Are you sexually active? ☐ **Yes** ☐ **No**

Are you using birth control? ☐ **Yes** ☐ **No** If yes, please include type: _____

Do you wish to become pregnant? ☐ **Yes** ☐ **No**

How old were you when you began to menstruate: _____

Are you still having periods?

☐ **Yes** If yes, date of the first day of your last period: _____

Usual duration of flow: _____ Periods occur every _____ days

Are you experiencing any of the below symptoms:

☐ Menstrual pain ☐ Spotting between periods

☐ Bleeding between periods ☐ Excessive bleeding

☐ **No** If no, how old were you when you stopped having periods? _____

Are you experiencing bleeding after menopause: ☐ **Yes** ☐ **No**

Date of last PAP smear:_____ Date of last Mammogram:_____ Date of last Colonoscopy:_____

Have you had an abnormal PAP test? ☐ **Yes** ☐ **No**

If yes, please list date and type of any treatments(s) received: _____

Breast Cancer or Breast Surgery Patient

Do you have a history of breast cancer? ☐ **Yes** ☐ **No** At what age were you first diagnosed? _____

If yes, which side? ☐ Right ☐ Left

Were you treated with: ☐ Lumpectomy ☐ Chemotherapy

☐ Mastectomy ☐ Radiation therapy

Were your lymph nodes checked? ☐ **Yes** ☐ **No** ☐ Hormonal therapy

Do you have a lump in your breast? ☐ **Yes** ☐ **No**

If yes, which side? ☐ Right ☐ Left

Does the lump hurt? ☐ **Yes** ☐ **No** Is the pain related to your cycle? ☐ **Yes** ☐ **No**

Has the lump increased in size? ☐ **Yes** ☐ **No** Do you have nipple discharge? ☐ **Yes** ☐ **No**

Do you have any breast skin changes? ☐ **Yes** ☐ **No** Have you had a breast cyst drained? ☐ **Yes** ☐ **No**

Do you have lumps in your underarm? ☐ **Yes** ☐ **No** Have you had a breast biopsy? ☐ **Yes** ☐ **No**

Have you had prior breast surgery? ☐ **Yes** ☐ **No** Have you had breast plastic surgery? ☐ **Yes** ☐ **No**

Have you ever taken hormones? ☐ **Yes** ☐ **No**

If yes, ☐ Birth control pills

☐ Hormone replacement

☐ Fertility