Compass Oncology
Patient History

Name: ____________________ Today's Date: __________

Date of Birth: __________ Referring Physician: __________

☐ Male ☐ Female Primary Care Provider: __________

OB/Gyn Physician: __________

Reason for Today's Visit: __________

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

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

☐	Condition	Date
☐	High Blood Pressure	
☐	High Cholesterol	
☐	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: __________

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

Vaccine	☐	Date	Vaccine	☐	Date	Vaccine	☐	Date
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: ______________________________

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** ☐ **No**
If yes, use per day: ☐ Cigarettes: ________ ☐ Cigars: ________ ☐ Pipe: ________ ☐ Chewing tobacco: ________
For how many years have you used the above tobacco product? ________

If 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? ________

Do you use marijuana? ☐ **Yes** ☐ **No**

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? ______________________________

What do you do for exercise? ________________ How many times per week? ________

Family History: Please include age at diagnosis

Please list all first, second and third degree family members with a history of cancer or colon polyps, either living or deceased.
First degree: Parents, siblings and children
Second degree: Grandparents, aunts/uncles, nieces/nephew, grandchildren and half siblings
Third degree: Great grandparents, great aunts/uncles, half aunts/uncles, first cousins and great grandchildren

Relationship to Patient	Maternal	Paternal	Cancer Type	Number of Polyps	Age at Diagnosis
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			

☐ Adopted - Family history not known ☐ Ashkenazi Jewish Ancestry

Do you have a family history of blood clots or bleeding disorders?
☐ **Yes** ☐ **No**
If yes, please elaborate: ______________________________

Compass Oncology Patient History

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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 or ankle
- ☐ *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
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stools
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Hemorrhoids
- ☐ *None*

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

Men only…
- ☐ Prostate infections
- ☐ Impotence

Women only…
- ☐ Vaginal discharge
- ☐ Vaginal 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: ______________________________

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** ☐ **No**

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

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 ☐ Mastectomy ☐ Chemotherapy ☐ Radiation therapy ☐ Hormonal therapy

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

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