COMPASS ONCOLOGY
GYNECOLOGIC ONCOLOGY & PELVIC SURGERY
PATIENT QUESTIONNAIRE

DATE: _______

FULL NAME:_________________________________DATE OF BIRTH:__________

PRESENT WEIGHT: ______WEIGHT 1 YR AGO: _______WEIGHT 5 YRS AGO: _______
HEIGHT: ____________

#OF PREGNANCIES: LIVE BIRTHS: ______MISCARRIAGES:______ABORTIONS:______
CESAREANS: _____PREMATURE BIRTHS: _______COMPLICATIONS:________________
____

PERSONAL HISTORY OF PAST ILLNESS: (CIRCLE ILLNESS THAT YOU HAD AND ADD DATES(S). If you still have the illness write "c" (current)

RHEUMATIC FEVER:____________	ANEMIA:_____________	STOMACH ULCER:________
HEART DISEASE: _____________	ARTHRITIS: __________	HEPATITIS: ____________
HEART MURMUR:______________	EPILEPSY: ____________	TUBERCULOSIS:_________
HIGH BLOOD PRESSURE:________	PNEUMONIA: _________	KIDNEY DISEASE: _______
VENEREAL DISEASE:___________	CANCER: _____________	EYE DISEASE:___________
LIVER DISEASE: ______________	DIABETES: ___________	MIGRAINE HEADACHES:___
SKIN TROUBLE:_______________	ALCOHOLISM:_________	HEAD INJURY: __________
LUNG CONDITION:____________	GOUT: _______________	THYROID DISEASE: ______

ARE YOU ALLERGIC TO ANY MEDICATIONS: YES: _________ NO: __________

If yes, please list medications and the reactions you had to them: ______________

____

____

SURGERIES: Please list all surgeries and hospitalizations:

DATE: SURGERY OR REASON FOR THE HOSPITAL STAY:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

DATE OF LAST COMPLETE PHYSICAL EXAM: ____________________________
BY DR: ____
DATE OF LAST PAP SMEAR: ____
DATE OF LAST MAMMOGRAM: ____
DATE OF LAST BONE DENSITY TEST: __________________________________
ARE YOU INTERESTED IN OBTAINING BONE DENSITY TEST ?: _____________

FAMILY HISTORY:

Please check appropriate box:

	Age:	Health:	Cancer:	High BP:	Diabetes:	Stroke:	Other
Father							
Mother							
Siblings							
1.							
2.							
3.							
4.							
5.							

SOCIAL:

MARRIED:____ SINGLE:____WIDOWED:____DIVORCED:____OTHER:____

OCCUPATION: ____

HABITS:

Do you use: Cigarettes:_______packs per day:_______how long?_________
Alcoholic beverages: ___________ # per week:_________ Caffeinated beverages:______

Have you ever used? Marijuana:_____LSD:_____Speed:_____Heroin:_____

MEDICATIONS:

1.____
2.____
3.____
4.____
5.____
6.____

Please include all medications including over the counter meds, vitamins or any naturopathic medications.

Please circle any of the conditions you have had in the past six (6) months:
Please fill in all blanks:

GENERAL: unusual fatigue or weakness, chills, fever, itching, unable to sleep, weight changes, bleeding tendency, frequent colds, excessive thirst

URINARY: pain/burning on urination, night frequency (excessive), day frequency, slow urine stream, lose urine w/cough, sneeze, discharge, bloody or dark urine

NERVOUS SYSTEMS: numbness, tingling, loss of sensation, paralysis, trembling, seizures, frequent headaches, dizziness, loss of balance, fainting spells.

STOMACH/INTESTINES: poor appetite, difficulty swallowing, frequent indigestion/heartburn, belching nausea/vomiting, diarrhea/constipation, change in bowel habits, hemorrhoids or piles, abdominal pain/stomach ache, intolerance to certain foods, bright blood n stool, use of antacids, pass gas often, anal itch, laxatives

HEART: high/low blood pressure, irregular or skipped heartbeats, racing or fluttering, pounding, chest pain on exertion, swollen feet, ankles, hands, heart murmur.

LUNGS: persistent cough, coughing up blood, pus, mucous, shortness of breath, wheeze, sit up to breath

EYES: wear glasses/contact lenses, change in vision, blurry vision, eye pain, sees double spots before eyes, blind areas

EARS: hearing loss, ringing in ears, infection, earache

NOSE: bleeding, stoppage, sinus trouble, post nasal drip, discharge

THROAT & MOUTH: dentures, sore mouth, tongue, lips, hoarseness, frequent sore throat, bleeding gums

BONES< JOINTS & MUSCLES: painful or stiff joints, back pain or burning legs/feet, cramps in muscles of legs, foot trouble, varicose veins, muscle weakness or soreness

MOOD: generally happy, lack of memory, depresses, irritable, worried about health, tense or under stress, work or family problems, desired psychiatric help, considered suicide
SEXUAL: unsatisfactory, trouble in performance, painful intercourse, bleeding w/intercourse, you/partner had genital warts

AGE OF FIRST INTERCOURSE: ____________
NUMBER OF LIFETIME PARTNERS: __________
ARE YOU CURRENTLY SEXUALLY ACTIVE: __________
Preference: MALE: ________ FEMALE: ________ BOTH: ________
MENSTRUAL: AGE OF ONSET: _________DATE OF LAST PERIOD__________
PERIODS OCCUR EVERY___________DAYS
BIRTH CONTROL METHOD: _____________________________
Menstrual pain, pre-menstrual tension, bleeding between periods, abnormal discharge, excessive bleeding, hot flashes, night sweats, sleeplessness, bleeding after menopause