



**COMPASS ONCOLOGY
GYNECOLOGIC ONCOLOGY/PELVIC SURGERY
PATIENT QUESTIONNAIRE**

Full Name _____ Date of Birth _____

Reason for Visit: _____

Personal Medical History		Date of Diagnosis	Personal Medical History		Date of Diagnosis
Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/> Alcoholism		<input type="checkbox"/>	<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/>	<input type="checkbox"/> Anemia		<input type="checkbox"/>	<input type="checkbox"/> Liver Disease	
<input type="checkbox"/>	<input type="checkbox"/> Arthritis		<input type="checkbox"/>	<input type="checkbox"/> Lung Condition	
<input type="checkbox"/>	<input type="checkbox"/> Blood Disorder/ Coagulopathy		<input type="checkbox"/>	<input type="checkbox"/> Mental Illness	
<input type="checkbox"/>	<input type="checkbox"/> Cancer (list type)		<input type="checkbox"/>	<input type="checkbox"/> Migraine Headaches	
			<input type="checkbox"/>	<input type="checkbox"/> Pneumonia	
			<input type="checkbox"/>	<input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/>	<input type="checkbox"/> Diabetes		<input type="checkbox"/>	<input type="checkbox"/> Skin Trouble	
<input type="checkbox"/>	<input type="checkbox"/> Epilepsy		<input type="checkbox"/>	<input type="checkbox"/> Stomach Ulcer	
<input type="checkbox"/>	<input type="checkbox"/> Heart Disease		<input type="checkbox"/>	<input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/>	<input type="checkbox"/> Heart Murmur		<input type="checkbox"/>	<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/>	<input type="checkbox"/> Hepatitis		<input type="checkbox"/>	<input type="checkbox"/> Other	
<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure		<input type="checkbox"/>	<input type="checkbox"/> Other	

Present Height: _____ Present Weight: _____ Approximate Weight 1 Year Ago: _____

What is the Most You Have Ever Weighed (not including pregnancy) _____ When _____

Please list any **medications** that you are currently taking (include birth control pills, over the counter medications and herbal/naturopathic medications). Please include dosages of each medication (if known).

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Are you allergic to any medications? Yes No

If yes, please list those medications that you are allergic to and the reactions that you had to them:

Please list any **surgeries** (include C-sections) and **hospitalizations** that you have had (please include dates)

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Gynecologic History:

Name of your primary care physician: _____ Date of Last Complete Physical Exam: _____

Name of your OB/GYN physician: _____

Date of last mammogram (if applicable): _____ Date of last colonoscopy (if applicable): _____

Date of last PAP smear: _____ Have you ever had an abnormal PAP test? Yes No
 If yes, please list date and type of any treatment(s) received _____

How many times have you been pregnant? _____ How many children do you have? _____

Any complications during pregnancy? _____ Any history of miscarriages or abortions? _____

Do you wish to become pregnant (again)? _____

Are you sexually active? _____ Are you using birth control? (If yes please list) _____

How old were you when you first started your period? _____

Are you still having periods? Yes No How old were you when you stopped having periods? _____ (skip to Family History)

Date of the first day of your last period: _____

Usual duration of flow: _____ Periods occur every _____ days.

Family History	Mother Age _____	Father Age _____	Brother(s) 1. Age _____ 2. Age _____ 3. Age _____	Sister(s) 1. Age _____ 2. Age _____ 3. Age _____	Other (Aunt, Uncle, Grandparent)
Cancer	Check if yes / Age at diagnosis	Check if yes / Age at diagnosis	Check if yes / Age at diagnosis	Check if yes / Age at diagnosis	Check if yes / Age at diagnosis / Relation
Breast	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Ovarian	<input type="checkbox"/> _____			<input type="checkbox"/> _____	<input type="checkbox"/> _____
Uterine	<input type="checkbox"/> _____			<input type="checkbox"/> _____	<input type="checkbox"/> _____
Cervical/Vaginal/Vulva	<input type="checkbox"/> _____			<input type="checkbox"/> _____	<input type="checkbox"/> _____
Colon	<input type="checkbox"/> _____			<input type="checkbox"/> _____	<input type="checkbox"/> _____
Other (please list type)	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Other (please list type)	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
High Blood Pressure	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Stroke	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____

SOCIAL HISTORY:

Marital Status: Married Single Divorced Widowed

Occupation (previous if retired): _____ Retired

Do you currently use tobacco products?

Yes. How many packs of cigarettes /cigars / chewing tobacco (circle one) do you use per day? _____

No. Have you ever used tobacco products in the past? Yes No

If yes, how many packs of cigarettes /cigars / chewing tobacco (circle one) do you use per day? _____

For how many years did you use the above tobacco product? _____

How many glasses/servings of wine, beer or other alcoholic beverage(s) do you drink per week? _____

Have you used illicit drugs in the past 5 years: Yes No

If yes, which ones? _____

Have you had any of these symptoms in the last six (6) months?

General

Have you gained or lost more weight?
 Have you felt fatigued?
 Have you had fevers?

Yes	No

Eyes

Do you wear glasses or contacts?
 Have you had pain in your eyes?

Ears, Nose and Throat

Have you been dizzy, ringing or buzzing?
 Do you have bleeding gums or mouth sores?
 Do you have a sore throat?

Heart

Do you have chest pains?
 Do you have palpitations?
 Do you use more than one pillow to sleep?
 Do you have swelling in your feet?
 Do you ever have to sit up at the edge of the bed to catch your breath at night?
 Do you get short of breath when you hurry or go up stairs?
 Have you been told you have a murmur?
 Have you had an EKG?

Lungs

Do you have shortness of breath?
 Do you have wheezing?
 Do you have a cough?
 Do you cough up phlegm or blood?
 Have you ever had a positive TB skin test?

Stomach, Intestines

Do you have abdominal pain?
 Do you have difficulty swallowing?
 Do you have nausea or vomiting?
 Do you have diarrhea?
 Do you have constipation?
 Do you have black stools?
 Do you have blood in your stool?
 Have you ever had jaundice or yellowish skin?

Urinary

Do you ever lose control of your urine?
 Do you have burning when you urinate?
 Do you get up at night to urinate?

Gynecologic

Do you have abnormal vaginal discharge or sores?
 Do you have painful intercourse?
 Do you have bleeding after intercourse?
 Do you have menstrual pain?
 Do you have irregular periods?
 Do you have excessive bleeding?
 Do you have bleeding in between periods?
 Do you have hot flashes?
 Do you have night sweats?
 Do you have sleeplessness?
 Have you had any post-menopausal bleeding?
 Have you had sexually transmitted disease or PID?

Yes	No

Skin

Do you have a rash or itching?
 Do you have any suspicious moles or spots?

Nervous System

Have you had a seizure?
 Have you fainted?
 Have you had weakness or numbness?
 Have you had paralysis or tingling?

Psychiatric

Have you felt depression or anxiety?
 Do you have memory problems?
 Do you have trouble sleeping?

Endocrine/Gland Problems

Do you have frequent thirst or frequent urination?
 Do you feel more hot/cold than others around you?

Blood Disorders

Do you bruise easily?
 Do you bleed abnormally?
 Do you have any enlarged lymph nodes?

Immune System

Do you get infections frequently?

--	--

Muscles, Joints

Do you get back pain or joint pain?
 Do you get stiffness or swelling of joints?
