



COMPASS ONCOLOGY PATIENT HISTORY

Please PRINT all information

DATE: _____

Name (first & last)	Age	Birth Date	Where Born
Address		Home Phone	
Occupation	How Long in Type of Work	Work Phone	
Referred by _____			

Reason for Seeking Medical Attention: (confidential items need not be stated)

FAMILY HISTORY	If Living		If Deceased		Has Any Blood Relatives Ever Had: (please circle)
	Age	Health	Age	Cause	
Father					Cancer
Mother					Sugar Diabetes
Brother or Sister					Heart Disease
1					High Blood Pressure
2					Mental Illness
3					Tuberculosis
4					Arthritis
5					Gout
Spouse					Kidney Stone
Children					Migraine Headache
1					Blood Disease
2					Goiter
3					Stroke
4					Allergy
5					Overweight

PERSONAL HISTORY OF PAST ILLNESSES: Please circle the Illness You Have Had, Include the Date

Rheumatic Fever:	Thyroid Disease:	Asthma/Hay Fever:
Heart Disease:	Eye Disease:	Deformity:
Heart Murmur:	Arthritis:	Skin Trouble:
High Blood Pressure:	Hepatitis:	Alcoholism:
Stomach Ulcers:	Liver Disease:	Broken Bones:
Anemia:	Epilepsy:	Head Injury:
Kidney Disease:	Migraine Headache:	Gout:
Tuberculosis:	Diabetes:	Lung Condition:
Pneumonia:	Cancer:	Other:
Venereal Disease:	Nervous Breakdown:	

LIST MEDICATION THAT YOU ARE ALLERGIC TO: Please include any reactions you have had

Present Weight: _____ Weight 1 Year Ago: _____ Weight 5 Years Ago: _____

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

SURGERIES: Please list all surgeries and hospitalizations

Date	Surgery or Reason for Hospitalization	Where	Doctor
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

Have You Ever Been Advised to Have Surgery Which Was Not Performed? _____

Date of Last Complete Physical Exam: _____ By Dr: _____ Normal / Abnormal

X-RAYS / CT SCANS / MRI:

Chest	Date	Normal / Abnormal
Stomach	Date	Normal / Abnormal
Gall Bladder	Date	Normal / Abnormal
Back	Date	Normal / Abnormal
Other	Date	Normal / Abnormal
Have You Ever Had an EKG	Date	Normal / Abnormal

IMMUNIZATIONS: Please list date of last vaccine

Small Pox	Measles	Flu
Polio	Typhoid	Hepatitis
DPT	Tetanus	Other

SOCIAL HISTORY:

Married: ____ Single: ____ Widowed: ____ Divorced: ____ Other: ____ How Long: ____
 Previous Marriages: ____ How Long: ____
 Religious Affiliation: _____
 Previous Occupations: _____
 When Did You Come to the Northwest: _____ Where Else Have You Lived: _____
 Describe a Typical Day: _____

HABITS: Please be specific about how much

Cigarettes: ____ packs/day Cigars: ____ Pipe: ____ Coffee/Tea: ____ cups/day
 Exercise: _____
 Experimental Drugs: Marijuana: ____ LSD: ____ Speed: ____ Heroin: ____ Other: _____
 Alcohol: _____ per/week
 Use of Alcohol/Medication Excessively: _____

MEDICATIONS:

Please list all medications you are currently taking, including vitamins, hormones, insulin, laxatives, any other)

1.	4.	7.
2.	5.	8.
3.	6.	9.

General	Breast	Bones/Joints/Muscles
Unusual fatigue or weakness	Lump	Painful, stiff, swollen joints
Chills, fever, itching	Pain	Back pain
Unable to sleep	Discharge	Pain or burning in legs/feet
Weight changes		Cramps in legs
Night sweats	Lung	Varicose veins
Bleeding tendency	Persistent cough	Muscle weakness
Frequent colds	Cough up blood, pus, or mucous	
Excessive thirst	Short of breath	Skin
	Wheeze	Rash, hives, or itching
Eyes	Need to sit up to breathe	Easily bruise
Glasses/contacts		Change in mole or wart
Change in vision	Stomach/Intestine	Dryness
Blurry vision	Poor appetite	Excess moisture
Eye pain	Difficulty swallowing	A sore that won't heal
Double vision	Frequent heartburn	
See spots	Belching	Mood
Blind areas	Nausea/vomiting	Memory loss
	Diarrhea	Tearful
Ears	Constipation	Depressed
Loss of hearing	Black stools	Irritable
ringing in ears	Change in bowels	Anxious
Infection	Hemorrhoids / piles	Worried
Ear ache	Abdominal pain	Shy
	Intolerance to certain food	Work / family problems
Nose	Red blood in stools	Frightening thoughts
Bleeding	Antacid use	Desired psychiatric help
Sinus trouble	Pass gas often	Thoughts of suicide
Post nasal drip	Anal itch	
discharge		Sexual
	Urinary	Unsatisfactory
Throat/Mouth	Pain / burning with urination	Trouble in performance
Wear dentures	Excessive night urination	Painful intercourse
Sore mouth, tongue, or lips	Excessive day urination	
Hoarseness	Slow starting or stopping	Menstrual
Frequent sore throat	Leak urine with a cough or sneeze	Age of onset
Bleeding gums	Bloody or dark urine	Last period
		Duration of menses days
Neck	Nervous system (where, when, etc.)	Last pap
Stiffness	Numbness	Menstrual pain
Pain	Tingling	Spotting between periods
Swelling	Loss of sensation	Unusual discharge
	Paralysis	Excessive bleeding
Heart	Trembling	Birth control
High or low blood pressure	Seizures	Hot flashes
Irregular / skipped beats	Frequent headaches	Bleeding after menopause
Racing / fluttering	Dizziness	
Pounding	Loss of balance	Pregnancies
Chest pain	fainting	Live births
Swollen feet, ankle, or hands		Miscarriages
Murmur		Abortions
		Cesareans
		Premature births
		Any complications