

Compass Oncology Medical History Form

First Name _____ M.I. _____ Last Name _____ DOB _____ Date _____

Please list all doctors involved with your care:

Personal History

Birthplace		Birth Date	
Marital Status		Health of spouse	
Ethnicity			
Close relative or family in area?			
Occupations			
Average per day use			
Alcohol			
Tobacco			

Blood Relatives:	Present Age or Age at Death	If Living, health (good, fair poor) If deceased, cause of death
Father		
Mother		
Brothers or Sisters		
1		
2		
3		
4		
5		
Children		
1		
2		
3		
4		
5		

Family History- Has any blood relative had any of the following: (Circle yes or no) If so, what relationship

	Yes	No	
Anemia			
Bleeding Tendency			
Tuberculosis			
Kidney Disease			
Asthma			
Other serious illness			
High Blood Pressure			

Cancer: List all blood relatives who have had cancer and describe the type of cancer.

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Personal Medical History

Circle Yes or No

	Yes	No
Polio		
Diabetes		
Infectious mono		
Valley Fever		
Tuberculosis		
Exposure to TB		
Malaria		
Pneumonia		
Hepatitis (Yellow Jaundice)		
Bladder infections		
Rheumatic fever		
Kidney disease		
Asthma		
Emphysema		
Arthritis		
High Blood Pressure		
Heart Disease		
Anemia		
Bleeding tendency		
Blood clot		
Blood transfusion		
Ulcer		
Cancer		
Exposure to Asbestos		
Other serious illness		

Explain all yes answers and list all previous surgeries:

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Immunizations

Have you received the following:

	Yes	No
Pneumovax		
Hemophilus (HIB)		
Hepatitis B		
Tetanus		
Polio		
Measles		

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Have you recently had or been bothered by: Circle yes or no. If in doubt, leave blank					
General			Palpitations	Yes	No
Tire easily, weakness	Yes	No	Digestive		
Weight change	Yes	No	Change in appetite	Yes	No
Night sweats	Yes	No	Difficulty swallowing	Yes	No
Persistent fever	Yes	No	Heartburn	Yes	No
Sensitivity to heat	Yes	No	Abdominal distress	Yes	No
Sensitivity to cold	Yes	No	Belching/excess gas	Yes	No
Skin			Abdominal enlargement	Yes	No
Eruptions (rash)	Yes	No	Nausea	Yes	No
Change in color	Yes	No	Vomiting	Yes	No
Eyes	Yes	No	Vomit blood	Yes	No
Trouble seeing	Yes	No	Rectal bleeding	Yes	No
Eye pain	Yes	No	Tarry stools	Yes	No
Inflamed eyes	Yes	No	Yellow jaundice	Yes	No
Double vision	Yes	No	Constipation	Yes	No
Ears			Diarrhea	Yes	No
Loss of hearing	Yes	No	Hemorrhoids	Yes	No
Ringing in ears	Yes	No	Urinary system		
Nose			Unable to hold urine	Yes	No
Loss of smell	Yes	No	Increase in frequency	Yes	No
Frequent colds	Yes	No	Pain or burning	Yes	No
Nosebleeds	Yes	No	Blood in urine	Yes	No
Mouth			Endocrine		
Sore gums	Yes	No	Thyroid trouble	Yes	No
Soreness of tongue	Yes	No	Diabetes	Yes	No
Dental problems	Yes	No	Muscles/Joints		
Throat	Yes	No	Cramping	Yes	No
Postnasal drainage	Yes	No	Weakness	Yes	No
Soreness	Yes	No	Pain in joints	Yes	No
Hoarseness	Yes	No	Swollen joints	Yes	No
Breasts			Nervous system		
Lumps	Yes	No	Headaches	Yes	No
Discharge	Yes	No	Dizziness	Yes	No
Heart/Lung			Fainting	Yes	No
Cough persisting	Yes	No	Convulsions or seizures	Yes	No
Sputum (phlegm)	Yes	No	Sleeplessness	Yes	No
Bloody sputum	Yes	No	Depression	Yes	No
Wheezing	Yes	No	Memory loss	Yes	No
Chest pain	Yes	No	Poor coordination	Yes	No
Pain with Breathing	Yes	No	Weakness or paralysis of muscles	Yes	No
Shortness of breath	Yes	No			
Difficulty breathing when lying down	Yes	No			
Swelling of ankles	Yes	No			

GYN/OB

Started menstruating at age _____ Date of last PAP test _____ Date of last period _____

Number of pregnancies _____ Number of Births _____ Number of miscarriages _____

Did you breast feed? _____ Your age at birth of 1st child _____.

