



**compass  
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**HEALTH QUESTIONNAIRE**

NAME:

DATE OF BIRTH

SOC SEC. NO.

Dear Patient:

This questionnaire is designed to help your doctors know your general medical history and to save you time during your initial evaluation. Because the information is important for your health care, please fill it out carefully and completely. This will become part of your medical record; all information is strictly confidential. Although the questionnaire is extensive, it is not designed to focus on your current problem. Your doctor will still need to ask you questions.

Thank-you for your cooperation.

SEX:		MARITAL STATUS:	
<input type="checkbox"/> Male	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Separated
<input type="checkbox"/> Female	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	

**A. GENERAL CONDITION**

1. My height is \_\_\_\_\_.
2. My weight is \_\_\_\_\_.
3. My regular weight is \_\_\_\_\_.
4. My current health allows me to: (Choose the single most appropriate response)
  - a. Be fully active and carry on normal activity.....
  - b. Perform activities such as light house work, office work, shopping etc; but not to perform strenuous activities.....
  - c. Take care of myself but not perform light work, I am out of bed more than half the day, and I get out of the house.....
  - d. Stay pretty much at home, in bed or chair more than half the day, but I'm able to take care of myself to some degree.....
  - e. Be confined to bed or chair all the time.....
5. With regards to pain, I am having:
 

No pain.....

Mild pain, requiring little or no medication.....

Moderate pain, requiring regular medication.....

Severe pain, requiring regular strong pain medication such as narcotics.....
6. My pain is:  Adequately controlled     Inadequately controlled

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**B. MEDICATIONS**

1. Are you allergic to any drugs?     YES                       NO

I am allergic to:

Drug	Reaction
a. _____	_____
b. _____	_____
c. _____	_____
d. _____	_____
e. _____	_____

**C. SURGERIES**

1. Have you ever had surgery?     YES                       NO

If yes list your operations:

Surgery Type	Year (approximate.)
a. _____	_____
b. _____	_____
c. _____	_____
d. _____	_____
e. _____	_____

2. Have you been hospitalized? (other than for your current problem or surgeries listed above)

Problem	Year (approximate.)
a. _____	_____
b. _____	_____
c. _____	_____
d. _____	_____
e. _____	_____

3. Have you ever had radiation?     YES                       NO

Problem	Year (approximate)
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a. \_\_\_\_\_	\_\_\_\_\_
b. \_\_\_\_\_	\_\_\_\_\_
c. \_\_\_\_\_	\_\_\_\_\_

Patient Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_

**D. WOMEN ONLY**

1. I have had \_\_\_\_\_ pregnancies and \_\_\_\_\_ children.

2. I still have menstrual cycles.  YES  NO

If yes:

a. My last menstrual cycle was \_\_\_\_\_ (date).

b. My cycles are:  Regular  Irregular

c. Have you had spotting or bleeding between cycles?  YES  NO

If no: a. I stopped having menstrual cycles at the age of \_\_\_\_\_.

b. Have you had abnormal bleeding recently?  YES  NO

3. Have you had an abnormal pap smear?  YES  NO

If yes when? \_\_\_\_\_ (date).

**E. BLOOD TRANSFUSIONS**

1. Have you ever had a blood transfusion?  YES  NO

If yes did you have a reaction?  YES  NO

My last transfusion was \_\_\_\_\_ (date)

**F. INJURIES:** Have you ever had an accident that required medical attention or hospitalization?  YES

NO

a. Year \_\_\_\_\_ Result \_\_\_\_\_.

b. Year \_\_\_\_\_ Result \_\_\_\_\_.

**G. ILLNESSES:** I have had the following illnesses:

**YES NO**

Measles.....

Mumps.....

Chicken Pox .....

Shingles .....

Tuberculosis .....

Rheumatic Fever .....

Valley Fever or Coccidiodomycosis.....

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**H. HEATH PROBLEMS:** Have you ever had any of the following health problems?

	YES	NO		
			Gall Stones.....	<input type="checkbox"/> <input type="checkbox"/>
			Bowel Disease.....	<input type="checkbox"/> <input type="checkbox"/>
Head injuries .....	<input type="checkbox"/>	<input type="checkbox"/>		
Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>		<b>YES NO</b>
Cataracts.....	<input type="checkbox"/>	<input type="checkbox"/>		
Other Eye Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis.....	<input type="checkbox"/> <input type="checkbox"/>
Recurrent Sinusitis.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones.....	<input type="checkbox"/> <input type="checkbox"/>
Nose Diseases.....	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Disease.....	<input type="checkbox"/> <input type="checkbox"/>
Mouth Diseases.....	<input type="checkbox"/>	<input type="checkbox"/>	BladderDisease.....	<input type="checkbox"/> <input type="checkbox"/>
Throat Diseases.....	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease.....	<input type="checkbox"/> <input type="checkbox"/>
Thyroid Diseases.....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis.....	<input type="checkbox"/> <input type="checkbox"/>
Deafness .....	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Disease.....	<input type="checkbox"/> <input type="checkbox"/>
Pneumonia.....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia.....	<input type="checkbox"/> <input type="checkbox"/>
Lupus.....	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder.....	<input type="checkbox"/> <input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/> <input type="checkbox"/>
Alcoholism.....	<input type="checkbox"/>	<input type="checkbox"/>	Seizure.....	<input type="checkbox"/> <input type="checkbox"/>
Drug Addiction.....	<input type="checkbox"/>	<input type="checkbox"/>	Spinal Cord Problems.....	<input type="checkbox"/> <input type="checkbox"/>
Collagen Vascular Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Other Neurologic Problems.....	<input type="checkbox"/> <input type="checkbox"/>
Pleurisy.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tense and Nervous...	<input type="checkbox"/> <input type="checkbox"/>
Pulmonary emboli (blood clots in the lungs.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Feel Depressed.....	<input type="checkbox"/> <input type="checkbox"/>
Blood Clots in Extremity.....	<input type="checkbox"/>	<input type="checkbox"/>	Have Problems Sleeping.....	<input type="checkbox"/> <input type="checkbox"/>
Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	Psychological Problems.....	<input type="checkbox"/> <input type="checkbox"/>
Chronic Bronchitis.....	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Problems.....	<input type="checkbox"/> <input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Other Problems.....	<input type="checkbox"/> <input type="checkbox"/>
Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Please	
Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____	
Heart Failure.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Heart Infection.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Fluid around the Heart.....	<input type="checkbox"/>	<input type="checkbox"/>		
Ulcer Disease.....	<input type="checkbox"/>	<input type="checkbox"/>		
Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>		
Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>		

**Patient Name** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

**I. CURRENT SYMPTOMS:** Have you had any of the following recently?

	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
Headache.....	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Veins.....	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness.....	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Feet or Legs.....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting.....	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Arm/Arms.....	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision.....	<input type="checkbox"/>	<input type="checkbox"/>	Nausea.....	<input type="checkbox"/>	<input type="checkbox"/>
Blurry Vision.....	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting.....	<input type="checkbox"/>	<input type="checkbox"/>
Blind Spots.....	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting Blood.....	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Eyes or Skin (Jaundice).....	<input type="checkbox"/>	<input type="checkbox"/>
Eye Swelling.....	<input type="checkbox"/>	<input type="checkbox"/>	Belly Pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Ear Pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Belly Swelling.....	<input type="checkbox"/>	<input type="checkbox"/>
Recent Changes in Hearing.....	<input type="checkbox"/>	<input type="checkbox"/>	Red Blood in Stools.....	<input type="checkbox"/>	<input type="checkbox"/>
Ear Discharge.....	<input type="checkbox"/>	<input type="checkbox"/>	Purple Blood in Stools.....	<input type="checkbox"/>	<input type="checkbox"/>
Recent Change in nose Breathing or stuffiness.....	<input type="checkbox"/>	<input type="checkbox"/>	Black Tarry Stools.....	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds.....	<input type="checkbox"/>	<input type="checkbox"/>	White Chalky Stools.....	<input type="checkbox"/>	<input type="checkbox"/>
Mouth Sore.....	<input type="checkbox"/>	<input type="checkbox"/>	Green or Yellow Stools.....	<input type="checkbox"/>	<input type="checkbox"/>
Mouth Pains.....	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Mouth Bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Urinating.....	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Lymphnodes.....	<input type="checkbox"/>	<input type="checkbox"/>	Pain During Urination.....	<input type="checkbox"/>	<input type="checkbox"/>
Stiff Neck.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination.....	<input type="checkbox"/>	<input type="checkbox"/>
Skin Rash.....	<input type="checkbox"/>	<input type="checkbox"/>	Pus in Urine.....	<input type="checkbox"/>	<input type="checkbox"/>
Skin Tumors.....	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine.....	<input type="checkbox"/>	<input type="checkbox"/>
Cough (dry) .....	<input type="checkbox"/>	<input type="checkbox"/>	Problems with Bladder or Bowel Control.....	<input type="checkbox"/>	<input type="checkbox"/>
Cough up blood.....	<input type="checkbox"/>	<input type="checkbox"/>	Feeling Cold.....	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breathe at Rest.....	<input type="checkbox"/>	<input type="checkbox"/>	Feeling Hot.....	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breathe with Exercise .....	<input type="checkbox"/>	<input type="checkbox"/>	Seizures or Fits.....	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breathe at Night.....	<input type="checkbox"/>	<input type="checkbox"/>	Personality Change.....	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breathe While Lying Flat.....	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss.....	<input type="checkbox"/>	<input type="checkbox"/>
Pain on Deep Breathing.....	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or Tingling.....	<input type="checkbox"/>	<input type="checkbox"/>
Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Strength in Specific Areas of Body.....	<input type="checkbox"/>	<input type="checkbox"/>
Chills.....	<input type="checkbox"/>	<input type="checkbox"/>	Decreased Coordination.....	<input type="checkbox"/>	<input type="checkbox"/>
Sweats.....	<input type="checkbox"/>	<input type="checkbox"/>	Speech Problem.....	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Decreased Coordination.....	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations.....	<input type="checkbox"/>	<input type="checkbox"/>	Other (Specify) _____		

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**J. FAMILY HISTORY**

My Father is  Alive  Dead at age\_\_\_\_\_, His Health problems include(d)

\_\_\_\_\_

\_\_\_\_\_

My Mother is  Alive  Dead at age\_\_\_\_\_. Her Health problems include(d)

\_\_\_\_\_

\_\_\_\_\_

I have \_\_\_\_\_brothers and/or sisters

\_\_\_\_\_ of them are well.

\_\_\_\_\_ have the following health problems:

\_\_\_\_\_

\_\_\_\_\_

I have \_\_\_\_\_ children.

\_\_\_\_\_ of them are well.

\_\_\_\_\_ have the following health problems:

\_\_\_\_\_

\_\_\_\_\_

Other than the above, there is cancer in the family as follows:

\_\_\_\_\_

\_\_\_\_\_

Other diseases in the family are:

\_\_\_\_\_

\_\_\_\_\_

Current living arrangements:

Live alone

With family members

With friend(s)

Do you have any concerns or would you like to discuss:

Transportation, home care assistance, health care expenses?  YES

NO

Support Groups, counseling  YES

NO

Patient Name \_\_\_\_\_

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**K. SOCIAL HISTORY**

I currently  do not work  work as \_\_\_\_\_.

I previously  did not work  worked as \_\_\_\_\_.

Does your work expose you to chemicals?  YES  NO

Specify: \_\_\_\_\_.

Do you currently smoke cigarettes?  YES  NO

If yes how many packs per day? \_\_\_\_\_

How long have you smoked? \_\_\_\_\_

Do you smoke cigars?  YES  NO If yes how many? \_\_\_\_\_ How long? \_\_\_\_\_

Do you smoke a pipe?  YES  NO If yes how many? \_\_\_\_\_ How long? \_\_\_\_\_

If you currently do not smoke, did you ever smoke?  YES  NO

If yes, when did you quit? \_\_\_\_\_

Do you currently drink alcohol?  YES  NO

If yes, please check correct response:

Occasionally  Frequently  Daily

I  have  have not had significant "recreational" drug exposure.

Have you recently traveled outside the US?  YES  NO

If yes, where? \_\_\_\_\_

Would you be interested in meeting with a person who has a condition similar to yours, or who is on the same treatment plan?  YES  NO

END (Thank you!)