Compass Health
SETTING A NEW DIRECTION IN HEALTH CARE
2175 Coolidge Road
East Lansing, Michigan 48823

Patient Medical Information Sheet

Patient Name:			Preferred Name:
Date:	Sex: ☐ Male ☐ Female	Date of Birth:	Age:
Chief Complaint (Why are you here)?			

** Will be updated with each visit as needed*

*Patient Medical History			*Past Surgical History		Prior Cancer Treatments	
Have you been diagnosed with: (check below)			Please include all minor surgeries (biopsies, cysts, etc.)		Radiation Therapy ☐ YES ☐ NO	
High Blood Pressure	☐ YES	☐ NO	Operation	Date	TX Area & Date	1.
Heart Problems	☐ YES	☐ NO				2.
Emphysema/COPD	☐ YES	☐ NO				3.
Stroke	☐ YES	☐ NO			Chemotherapy ☐ YES ☐ NO	
Diabetes - Type:	☐ YES	☐ NO			Drug & Date	1.
Arthritis	☐ YES	☐ NO				2.
Headaches	☐ YES	☐ NO				3.
Depression	☐ YES	☐ NO			Traveled Outside Of The USA?	
Asthma	☐ YES	☐ NO			When:	
Cholesterol problems	☐ YES	☐ NO			Where:	
Dementia/Alzheimer's	☐ YES	☐ NO			Immunizations	
Previous Cancer -Type:	☐ YES	☐ NO			Influenza Vaccine ☐ YES ☐ NO	
Do you have a pacemaker?	☐ YES	☐ NO			Pneumonia Vaccine ☐ YES ☐ NO	
Other:						

Patient Medical History Continued		
Constitutional	☐ Normal	Loss of appetite / Fatigue / Weight loss (how many lbs.: __________)
Skin	☐ Normal	Rash / Bumps / Itching
HEENT	☐ Normal	Visual changes / Glasses / Contacts / Jaw pain / Hearing / Taste change
Respiratory	☐ Normal	Shortness of breath / SOB with exertion / Wheezing / Cough / Blood in sputum / Sputum production
Cardiovascular	☐ Normal	Breathing pain / Chest pain / Murmur / Skipped beats
Genitourinary	☐ Normal	Pain with urination / Frequent urination / Hesitancy / Hemorrhoids / Nocturia (Amount: ___________)
Gastrointestinal	☐ Normal	Nausea / Vomiting / Abdominal pain / Constipation / Diarrhea / Blood in stool / Cramping / Bloating / Heartburn
Musculoskeletal	☐ Normal	Aching / Stiffness / Joint pain / Difficulty walking
Neurologic	☐ Normal	Headache / Numbness / Seizure/ Weakness / Vision loss / Double vision
Hematologic	☐ Normal	Anemia / Easy bleeding / Bruising / Swollen glands
Immunological	☐ Normal	Allergies / Hives / Rash / Swollen glands / Night sweats
Endocrine	☐ Normal	High sugars / low sugars / Flushing / Heat or cold intolerance
Breast	☐ Normal	Pain / Mass / Drainage / Skin change / Nipple discharge

*Allergies					*Medications			
Are You Allergic To:			Reaction:	Year Experienced:	Name	Dose	Amount	Frequency
Aspirin	☐ YES	☐ NO						
Penicillin	☐ YES	☐ NO						
Sulfur Prep.	☐ YES	☐ NO						
Codeine	☐ YES	☐ NO						
Latex	☐ YES	☐ NO						
IV contrast	☐ YES	☐ NO						
Tape	☐ YES	☐ NO						
Sea Food	☐ YES	☐ NO						
Eggs	☐ YES	☐ NO						
Other(s):								

Patient Name:

Family Medical History

Mother	☐ Alive	Age:	☐ Dead	Year of Death:	Age at Death:	Health Problems:
Father	☐ Alive	Age:	☐ Dead	Year of Death:	Age at Death:	Health Problems:
Brother(s)	☐ Alive	Age(s):	☐ Dead	Year of Death:	Age at Death:	Health Problems:
Sister(s)	☐ Alive	Age(s):	☐ Dead	Year of Death:	Age at Death:	Health Problems:

Family History of Cancer: ☐ Yes ☐ No If yes, please list family member and type of cancer:

Other:

Social History

Marital Status: ☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed	☐Domestic Partnership

Occupation:	Employer:	If retired, prior occupation:

Use of alcohol:	☐ Currently (How many per week? ________)	☐ Never	☐ Previously quit (___drinks a day for ___years)
Smoking tobacco:	☐ Currently (____ packs a day for ____ years)	☐ Never	☐ Previously quit (___packs a day for ___years)
Smokeless tobacco:	☐ Currently (____a day for ____ years)	☐ Never	☐ Previously quit (___a day for _____years)
Use of drugs:	☐ Currently (Please list:____________________)	☐ Never	☐ Previously quit (Please list:________________)

Would you like information on smoking cessation? ☐ YES ☐ NO

Gynecological History

Age at first menstration _____	Age at menopause ___	Have you ever taken hormones? ☐ YES (How long? ____) ☐ NO	
Number of pregnancies _____	Number of children ___	Your age with first child _____	Perform Self Breast Exams ☐ YES ☐ NO
Did you breast feed? ☐ YES (How long? _____) ☐ NO		Did you take birth control? ☐ YES (How long? ______) ☐ NO	
Date of last PAP Smear __________	Date of last Mammogram _____________	Are you currently pregnant? ☐ YES ☐ NO	

Other:

Male Reproductive History

Prostate Biopsy ☐ YES (When? ___________) ☐ NO	Prostatectomy ☐ YES (When? _________) ☐ NO
Vastectomy ☐ YES (When? ___________) ☐ NO	Hormone Therapy ☐ YES (When? _________) ☐ NO

Other:

Rate Your Current Pain

(0 being no pain - 10 being severe pain)

0	1	2	3	4	5	6	7	8	9	10