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

Patient Medical Information Sheet

Name:	Pt I.D. #	Current Age:	Today's Date:
Referring Physician:		Primary Physician:	
Pharmacy:	Location:	Phone:	
Chief Complaint (Why are you here)?		Your email:	

**** Denotes Problem Summary Log- will be updated with each visit as needed***

***Patient Medical History**			***Past Surgical History**			
Have you been told you have	(check below)		List all operations (include minor surgeries, examples biopsies, hemorrhoids, cyst.ect.			
High Blood Pressure	☐ YES	☐ NO	Operation	Date	Surgeon	City/state
Heart Trouble	☐ YES	☐ NO				
Emphysema / COPD	☐ YES	☐ NO				
Stroke	☐ YES	☐ NO				
Diabetes Type:	☐ YES	☐ NO				
Arthritis	☐ YES	☐ NO				
Headaches	☐ YES	☐ NO				
Depression	☐ YES	☐ NO				
Asthma	☐ YES	☐ NO				
Cholesterol problems	☐ YES	☐ NO				
Weight Loss (how much)_____?	☐ YES	☐ NO				
Cancer Type:	☐ YES	☐ NO				
Other: (list)						

Patient Medical History continued		
Constitutional	☐ Normal	Weight loss / Loss of appetite / Fatigue
Skin	☐ Normal	Rash / Bumps / Itching
HEENT	☐ Normal	Visual changes / Glasses / Contacts / Jaw pain / Hearing
Respiratory	☐ Normal	Shortness of breath / Wheezing / Cough / Blood in sputum
Cardiovascular	☐ Normal	Breathing pain / Chest pain / Murmur / Skipped beats / Swelling / Prop up to sleep / Cramping with exercise
Genitourinary	☐ Normal	Pain with urination / Frequent urination / Hesitancy
Gastrointestinal	☐ Normal	Nausea / Vomiting / Abdominal pain / Constipation / Diarrhea / Blood in stool / Cramping / Bloating / Heartburn
Musculoskeletal	☐ Normal	Aching / Stiffness / Joint pain / Difficulty walking
Neurologic	☐ Normal	Head ache / Numbness / Burning / Seizure
Hematologic	☐ Normal	Anemia / Easy bleeding / Bruising / Swollen glands
Immunological/allergic	☐ Normal	Allergy / Hives / Rash / Swollen glands / Night sweats
Endocrine	☐ Normal	High/low sugars / Flushing / Heat or cold intolerance
Breast	☐ Normal	Pain / Mass / Drainage / Skin change

Allergies (are you allergic to) *Updated with each visit as needed		
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: (list)		

Medications *Updated with each visit as needed		
Name	Amount	How Often
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8		
9.		
10.		

Any Prior Cancer Treatments		
Radiation Therapy	☐ YES	☐ NO
TX Site & Date: 1.		
2.		
3.		
Chemotherapy	☐ YES	☐ NO
Drug & Date 1.		
2.		
3.		
Immunizations		
Influenza Vaccine	☐ YES	☐ NO
Pneumo Vax	☐ YES	☐ NO

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Patient Medical Information Sheet

Continued

Name:	Pt I.D. #	Current Age:	Today's Date:

Family Medical History					
Mother	☐ Alive	☐ Dead	Year of death	Age___	Health Problems?
Father	☐ Alive	☐ Dead	Year of death	Age___	Health Problems?
Brother(s)	☐ Alive	☐ Dead	Year of death	Age___	Health Problems?
Sisters(s)	☐ Alive	☐ Dead	Year of death	Age___	Health Problems?
Family History of cancer?		☐ Yes ☐ no	If yes which family member and what type of cancer?		

Social History					
Marital status	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
Occupation			If retired prior occupation		
Use of alcohol	☐ Never	☐ Some how many a week _____ (example 3-4 beer ,wine liquor).			
Smoke tobacco	☐ Never	☐ Currently __ packs a day for ___ years		☐ Previously quit __ packs a day for ___ years	
Smokeless tobacco	☐ Never	☐ Currently __ packs a day for ___ years		☐ Previously quit __ packs a day for ___ years	
Use of drugs	☐ Never	☐ Currently what drug? _____ How many years? _____		☐ Previously, but quit what drug? _____ How many years? _____	

Gynecological History (women only)						
Age at first menstrual?		# Of miscarriages?		Did you breast feed?	☐ Yes ☐ no	Hormone replacement therapy ☐ Yes ☐ No for how long? _____
# Of pregnancies?		Your age with first child?		Have you ever taken hormones?	☐ Yes ☐ no	
# Of children?		Age of menopause?		Did you take Birth Control ? ☐ Yes ☐ no for how long?		
Last PAP Smear	Date:	Last Mammogram	Date:	Misc:		

Information Below to be Completed by Nursing Staff

Pain Scale 0-10 numeric pain distress scale

0	1	2	3	4	5	6	7	8	9	10

Physical Examination

B/P #1 / time___:___	Pulse	Resp	Temp	Height ___'___" or____cm's
B/P #1 / time___:___	Weight _____lbs / ____Kg	BMI	Fatigue 0 1 2 3 4 5	KPS: