

CANCER INFORMATION

Have you ever been diagnosed with cancer, a mass or tumor? Yes No When? _____
Location _____ Type? _____
Current Status (eg: post surgery, recurrence etc.) _____
Current Stage _____
Relevant tumor markers _____

CONVENTIONAL TREATMENT HISTORY

Date **Surgery/Chemotherapy/Radiation/Other** **Dose (eg; chemo agents)** **Duration**

If you are in a clinical trial or experimental protocol please provide details. _____

CURRENT/RECENT HEALTH CARE PROVIDERS (Surgery, Oncology, Primary Care Providers etc.)

Name **Dates** **Care Provided**

ALLERGIES

Drug allergies (penicillin, etc.): _____
Allergies to foods, pollens, etc.: _____

HOSPITALIZATIONS/SURGERY (NON CANCER)

Date **Hospital** **Diagnosis/Operation** **Doctor**

ACCIDENTS / INJURIES Briefly describe

MORE than 5 years ago _____
LESS than 5 years ago _____

FAMILY HISTORY

Please include any of the following: Alcoholism, high blood pressure, cancer, diabetes, heart disease, osteoporosis, other addiction or illness.

Member	Living?	Age	Important Diseases	Cause of death	Age
Mother					
Father					
Siblings					
Siblings					
*MGM					
*MGF					
*PGM					
*PGF					

* M = Maternal P = Paternal GM = Grandmother GF = Grandfather

PERSONAL HISTORY

In general, I feel my overall health is: Excellent Good Fair Poor

MARK THE FOLLOWING: 1 - IF CURRENT, 2 - IF PAST

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> asthma | <input type="checkbox"/> ringing in ears | <input type="checkbox"/> palpitations | <input type="checkbox"/> migraines |
| <input type="checkbox"/> bronchitis | <input type="checkbox"/> sciatica | <input type="checkbox"/> tightness in chest | <input type="checkbox"/> frequent headaches |
| <input type="checkbox"/> pneumonia | <input type="checkbox"/> frequent urination | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> frequent depression |
| <input type="checkbox"/> frequent colds/flu | <input type="checkbox"/> dribbling urine | <input type="checkbox"/> heart problems | <input type="checkbox"/> jaundice |
| <input type="checkbox"/> Epstein-Barr | <input type="checkbox"/> painful urination | <input type="checkbox"/> poor sleep | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> scanty urination | <input type="checkbox"/> hypoglycemia | <input type="checkbox"/> hemorrhoids |
| <input type="checkbox"/> mononucleosis | <input type="checkbox"/> blood in urine | <input type="checkbox"/> severe mood swings | <input type="checkbox"/> eye problems |
| <input type="checkbox"/> HIV positive | <input type="checkbox"/> prostate problems | <input type="checkbox"/> diabetes | <input type="checkbox"/> photophobia |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> no/low sex drive | <input type="checkbox"/> overweight | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> allergies | <input type="checkbox"/> impotence/frigidity | <input type="checkbox"/> underweight | <input type="checkbox"/> stroke |
| <input type="checkbox"/> sinus congestion | <input type="checkbox"/> afternoon persp/fever | <input type="checkbox"/> eating disorder | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> colitis | <input type="checkbox"/> night sweats | <input type="checkbox"/> gum/teeth problems | <input type="checkbox"/> drug addiction |
| <input type="checkbox"/> Chron's | <input type="checkbox"/> hearing problem | <input type="checkbox"/> lots of fillings | <input type="checkbox"/> alcoholism |
| <input type="checkbox"/> diverticulitis | <input type="checkbox"/> tinnitus | <input type="checkbox"/> TMJ | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> parasites | <input type="checkbox"/> memory difficulty | <input type="checkbox"/> concussion | <input type="checkbox"/> frequent anger |
| <input type="checkbox"/> gas | <input type="checkbox"/> anxiety | | <input type="checkbox"/> frequent frustration |
| <input type="checkbox"/> bloating | <input type="checkbox"/> arthritis | | |

OTHER _____

HEIGHT _____ WEIGHT _____ BLOOD PRESSURE _____

SKIN DRY OILY NORMAL

PLEASE RATE THE FOLLOWING ON A SCALE OF 1 TO 10: (10 BEING THE BEST) – & WRITE IN ANY COMMENTS

Sleep _____

Energy Level _____

Appetite _____

Digestion _____

Any gas, bloating or other discomfort after eating: Yes No Describe: _____

STOOLS float sink daily bad odor no odor blood in stool

Do you rely on any of the following for bowel elimination? Yes No How often? _____

enemas laxatives purgatives What type/brand? _____

PERSONAL

How do you feel about the following areas of your life?

Please check appropriate boxes & make any comments you would like to

GREAT GOOD FAIR POOR COMMENTS

	GREAT	GOOD	FAIR	POOR	COMMENTS
Self					
Work					
Partner					
Sex					
Family					
Diet					
Excercise					

PERSONAL STRESS

PLEASE RATE YOUR STRESS ON A SCALE OF 0 TO 10: (10 BEING THE MOST) – & WRITE IN ANY COMMENTS

Stress Level _____

- 1. I worry a great deal Yes No
- 2. I feel lonely Yes No
- 3. I am bored with my life Yes No
- 4. I think a lot about dying Yes No
- 5. I have particular concerns relating to my religion Yes No
- 6. I feel fearful or afraid Yes No
- 7. I feel nervous most of the time Yes No
- 8. I often feel depressed Yes No
- 9. I feel anxious often Yes No
- 10. I am ill frequently Yes No
- 11. I sometimes feel weak or light-headed Yes No
- 12. I often have pains in my shoulders, neck or back Yes No
- 13. I often feel like crying Yes No
- 14. I lose my temper more than I used to Yes No
- Other personal concerns Yes No

Please describe _____

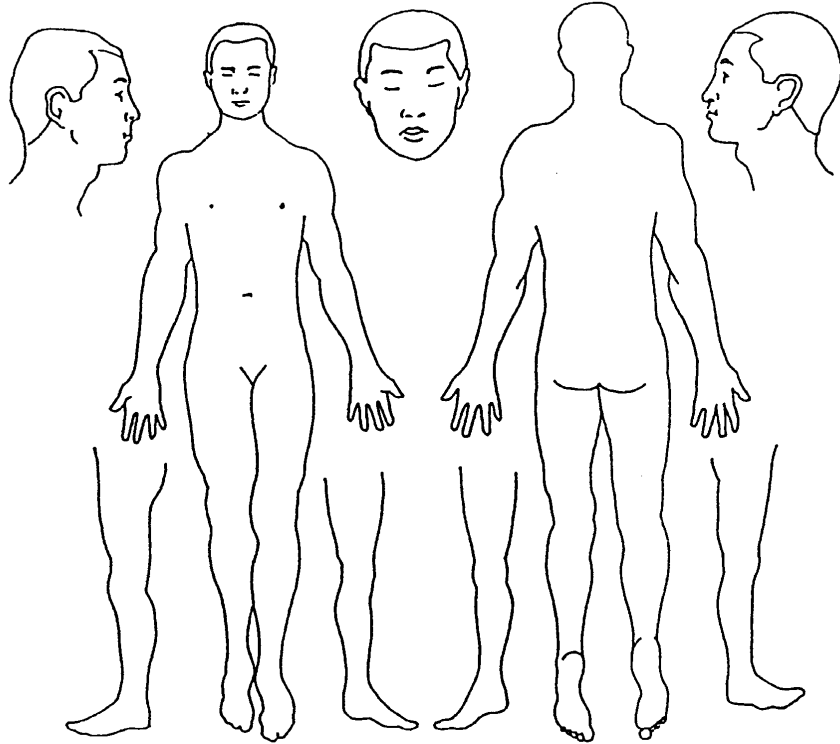
Please use this space to add any other information about yourself that you think will be of help to us:

PAIN

DO YOU HAVE ANY PAIN(S)?

Yes No

Please indicate painful or distressed areas



AREA/DESCRIPTION OF SYMPTOMS

PAIN LEVEL: 0 TO 10
(10 BEING THE HIGHEST)

FREQUENCY

FOR WOMEN ONLY!

MENSTRUAL PERIODS

Please complete this section to the best of your ability even if you no longer menstruate. It provides valuable information for an accurate assessment.

Since age _____ Regular? _____ Length of cycle _____ Flow lasts how many days? _____
Light _____ Heavy _____ Clots? _____ Color of blood _____
DATE OF LAST MENSES _____ PMS? _____ Describe symptoms: _____

MENSTRUAL CRAMPS? _____ Which Days? _____

HISTORY

MARK THE FOLLOWING: 1 IF CURRENT, 2 IF PAST

___ hysterectomy	___ herpes	___ mastectomy
___ D&C	___ yeast infections	___ lumpectomy
___ tubular ligation	___ interstitial cystitis	___ breast reconstruction
___ ablation	___ infertility	___ breast implants
___ irregular PAP smear	___ pain with intercourse	___ osteoporosis
___ fibroids	___ dryness with intercourse	
___ irregular bleeding		

VAGINAL DISCHARGE? _____ Color _____ Frequency _____ Amount _____

PREGNANCY/BIRTH CONTROL

Are you pregnant now? _____ Do you think you may be? _____
Number of pregnancies _____ Number of children _____
Terminations? _____ Miscarriages? _____ Tubular pregnancies? _____

Difficulty in conceiving? _____

Birth control method(s) _____

MENOPAUSE

No menses since _____

Experiences/symptoms you are currently feeling/having? _____

Experiences/symptoms you had in the past during menopause? _____