Cancer Immunotherapy Centers®

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Date: ____________________

Please note: Your medical history is very important to us. Please take the time to complete this confidential form as accurately and completely as you can. If you need more space, please use the back of each page. Thank you.

PATIENT INFORMATION:

DIAGNOSIS: ______________________________
Date of Initial Diagnosis: ______________________________
ALLERGY: ______________ Type of Reaction: ______________

YOUR PHYSICIANS:
1. Primary Care Physician (Family Doctor): ______________________________
2. Oncologist (Cancer Specialist): ______________________________
3. Other Health Care Professionals involved in your care: ______________________________

WHAT TYPE OF TREATMENT(S) HAVE YOU HAD SO FAR?

1. Surgery (State date and type of procedure done): ______________________________
2. Chemotherapy (State date and name of drugs/agents given: ______________________________
____
3. Radiation Therapy: State date and number of treatments given: ______________________________
____
4. Hormonal Therapy: State date and agent(s) given: ______________________________
____
5. Immunotherapy (Biological Response Modifier Therapy) (State date and agent(s) given):
____
6. Vaccine(s): (State date and type of agent(s) given): ______________________________
7. Integrative / Complementary / Alternative Treatments given: ______________________________
____
8. Other Therapies (State date and type(s) of agent(s) given): ______________________________
____

PRE-NATAL/BIRTH HISTORY:

Born at weeks gestation: ____

Did your mother have any significant problems during her pregnancy? ______________________

____

Did your mother have any significant problems after delivery? ___________________________

____

Were you breast or formula fed as a baby? ____________________________________

Did you have or are you aware of any significant childhood illnesses? ______________________

____

Were your childhood developments/milestones normal? ___________________________

Did you receive the usual childhood immunizations? ______________________________

Did you have any reaction(s) or side effects from the vaccines? _________________________

____

Have you had regular flu shots given to you? ____________________________________

EDUCATION:

What level of education have you completed: (Circle the appropriate choice)
Grade: _______________
College: (State diploma/degree): ____
University: (State course/degree): _______________________________________
Other trade or profession: ____

EMPLOYMENT HISTORY:

Your profession/occupation: ____

How long have you been working? _______________________________________

Briefly describe the nature/duties at your job: ___________________________________

____

What other jobs have you had in the last 10 years? _________________________________

Is the nature of your job stressful? ______________________________________

Did you ever take time off work related to job stress? ______________________________

Are you working at the present: *NO / YES*

If *NO*, when was the last day you worked? ______________________________

SOCIAL AND FAMILY HISTORY:

Smoker: *NO / YES/ QUIT*

if *YES or QUIT*: No. of cigarettes/day: __________ No. of years you smoked: __________

Alcohol: *NO / YES/ SOCIALLY*

if *YES*: No. of drinks consumed/week: __________ No. of years you drink: ___________

Caffeine: *NO / YES* No. of cups of coffee/tea per day: ___________

Marital status: (Circle the appropriate choice):

Single / Married / Divorced / Widowed / Separated / Common Law

How old is your spouse/partner? ____

What type of work / profession / occupation do they do? ___________________________________

How many children do you have? (State *m* for male and *f* for female and give their age):

____

What type of dwelling do you live in? ____

Father: (State age / significant illnesses): ____

Mother: (State age / significant illnesses): ____

Brother(s): (State age / significant illnesses): ____

Sister(s): (State age / significant illnesses): ____

PERSONAL HISTORY:

Circle relevant issues which apply to you from the list below:

Alcohol abuse
Children and In-law Problems
Disability Pension
Employment
Exposure to Radiation
Family Problems
Frequent antibiotic use
Others:

Frequent Infections
Injuries
Marital discord/ Disharmony
Motor Vehicle Accident
Possible exposure to toxins
Relationship Issues

Stress
Substance abuse
Trauma
Work Environment
Work related accident/ Injury

SEXUAL HISTORY:

Circle which apply to you from the list below:

Use Protection / High risk activities / Multiple partners
Sexually transmitted disease: ____
HIV/ AIDS: ____

SLEEP HISTORY:

Is the quality of your sleep good: *NO / YES*

*H*ow many hours per night do you sleep? ____

Do you require medication(s) to fall asleep? *NO / YES*

-if *YES*, give name and how long you are using this medication - include both over the counter and prescription): ____

DIET/APPETITE / WEIGHT / EXERCISE:

Diet: # of meals per day ___________ # of snacks per day _________________ example of type of food you eat): breakfast: ____
Snack: ____________________ Lunch: ____
Snack ______________________ Dinner: _____________________ Snack: ________________
Appetite: __________________ Weight: ____________kg / __________Pounds
Is it stable? ________________Exercise: (state type of exercise and frequency):
____
Please list all prescription medications you are presently taking: (state name / dose / date you started the medication): ____
____
Please list all non-prescription medications you are presently taking: (Include all herbal / natural medications / over the counter / street drugs / vitamin supplements / any other substances you are taking) ____
____
____
Please state most significant problem(s) or concern(s) you have: ___________________________
____

YOUR PAST MEDICAL HISTORY:

Please list all relevant medical problems you have had in your life:

Past medical/ surgical history: ____
____

Obstetrical and Gynecological history:

Number of times you have been pregnant? ________ Total No. of live Births? ______

No. of stillbirth(s)? _______ No. of abortions? _______ (spontaneous / therapeutic)

Other relevant gynecological history? ____
____

SIGNIFICANT INVESTIGATIONS:

Please circle and state all relevant investigation(s) you have had in the last 6 month:

Blood work / X-rays / Ultrasound / Gastroscopy / Colonoscopy / Mammography / CT-Scans / MRI Scan(s) / PET Scan(s) / Bone Scans / Other: ____
____

Studies you have had, include the result(s) if known: _____________________________________
____

PAST ILLNESSES OR MEDICAL PROBLEMS:

Circle relevant problems which apply to you from the list below

Abnormal TB Skin Test	Emotional Problems	Mononucleosis
Anemia	Emphysema	Mumps
Angina	Frequent Bladder Infection	Parasites
Anxiety	Gallbladder Disease	Pleurisy
Arthritis	Glaucoma	Pneumonia
Asthma	Gout	Polio
Bleeding Tendency	Hay Fever	Prostate Trouble
Blood Clots	Heart Murmur	Rheumatic Fever
Blood Disease	Hepatitis	Scarlet Fever
Broken bones	Herpes Zoster (Shingles)	Stomach Aches
Bronchitis	High Blood Pressure	Strep Throat
Cancer(s)	High Cholesterol	Stroke
Cardiac Arrhythmia	Influenza	Thyroid Disease
Cataracts	Kidney Disease	Tuberculosis
Chicken Pox	Kidney Stone	Ulcer Disease
Cirrhosis	Lupus	Vein Problems
Colitis/Irritable Bowel	Malaria	Venereal Disease
Depression	Measles	
Diabetes	Meningitis	

CURRENT REVIEW OF SYSTEMS

Circle relevant problems which apply to you from the list below

Recent Weight Change: *None / Loss / Gain* of ____________Pounds since _______________

Present Weight: ___________ Usual Weight: _________ Greatest Weight: __________________

Height: ______________

EYES

Blind Spots	Contacts	Head Trauma
Blindness	Dry Eyes	Inflammation
Color Blindness	Headache	Pain

Shimmering spots	Tearing Vision: Blurred, Double	

EARS

Discharge	Hearing Problems	Ringing Infections
Hearing Aid	Pain	Other:

MOUTH

Change in Taste	Gum Disease	Tongue: Sore, Enlarged
Dentures	Pain	Ulcers
Drooling	Partial Plates	
Dry Mouth	Teeth Problems	Other:

NOSE & THROAT

Change in Smell or Voice	Nasal Obstruction	Sinus Problems
Head Colds	Nose Bleeds –	Other:
Hoarseness	Runny Nose	

RESPIRATORY

Abnormal Chest X-Ray	Dry Cough	Positive TB Skin Test
Chest Pain	Moist Cough Color:	Shortness of Breath
Chills/ Fever	Night Sweats	Wheezing

CARDIOVASCULAR

Abnormal Cardiogram (EKG)	Pain: Jaw, Neck, Chest, Mid-Back	Shortness of Breath with Exertion
Angina/Chest Pain	Rapid Heat Beat	Swollen Feet or Ankles
Irregular Heart Beat (Palpitations)	Shortness of Breath at Rest	Varicose Veins of Phlebitis
Leg Cramps	Shortness of Breath when Lying Flat	Other:

GASTROI NTESTI NAL

Abdominal Pain	Food Intolerance or Allergy	Reflux, Hiatus Hernia
Belching		Stool: Black White Bloody
Bloating	Gallbladder Problems	Trouble Chewing
Bowels: Frequency	Heartburn	Trouble Swallowing
Change in Stool Size	Hemorrhoids	Vomiting
Constipation	Nausea	
Diarrhea	Poor Appetite	Other:

MUSCULOSKELETAL

Back Pain	Handicap	Muscle Pain
Bone Pain	Joint: stiffness, swelling, pain or redness.	Sprains
Dislocations		

List affected joints: ____

List broken bones: ____

HEMATOLOGICAL

Swollen Node(s):
Any areas that bleed, list: ____

NEUROLOGICAL & PSYCHOLOGICAL

Anxiety
Convulsions
Daydreaming
Depression
Difficulty Walking in the Dark
Dizziness
Fainting
In coordination
Irritability
Loneliness
Loss of Temper Fatigue
Nervousness
Numbness
Paralysis
Personality Change
Seizures
Suicidal Thoughts
Thick Speech
Tingling
Unconsciousness
Weakness
Worry

ENDOCRINE & METABOLISM

Appetite Change
Feel Too Cold
Feel Too Hot
Hot Flashes
Increase Thirst
Poor Energy

SKIN

Biopsy or Removal of Lesion
Change in Birthmarks,
Hair, Nails
Dryness
Itch Burning
Rash
Skin Cancer
Sore that does not heal

GENITOURINARY

Dark or Red Urine
Incontinence
Pain with Urination or Intercourse

Urinate Frequently During the Day: _____________times
Urinate frequently during the Night _____________times
Urine Stream: weaker, smaller, dribbling, difficulty in starting or stopping

SEXUALITY

Are you sexually active? *No Yes*, How often? ______________________
Are you having any problems with sexuality / ejaculation as a result of cancer or its treatment?
____

MEN
Penis: Soreness, Discharge, Burning, Pain Testicle: Pain, Swelling, Lump

WOMEN
Age at first period _____________ Age at Menopause _______________________
Menses: Irregular /Heavy Painful /Abnormal Bleeding /Discharge
Date of last Menses ____
Number of Pregnancies Deliveries _____________ Therapeutic Abortions _________
Miscarriages ________Complications _____________________________________
Did you ever use fertility drugs? *No Yes* If yes, which ones ______________________
Age at first pregnancy ______________ Did you breast feed? ________________
Birth Control Pills? *No/Yes* If yes, for how long? _______________ When did you last take them? _____________________ Hormonal Replacement Therapy (such as Estrogen) _______________________ If yes, what & when? ________________

Did you ever take Diethylstilbestrol (DES)? *No/ Yes*
Mother took Diethylstilbestrol (DES) *Yes/No*
Breast: Lump/ discharge /pain/ swelling
Please explain, including treatments: ____

Have you ever had to cope with a major illness of your own or a person close to you? *Yes/No*
Do you know anyone who has received treatment for cancer including radiation or chemotherapy? *Yes/ No*
Have you known anyone with an illness similar to yours? *Yes/No*
Have you ever seen a therapist or counselor? - *Yes/No*
Would you be interested in:

- Individual supportive counseling during your treatment? *Yes/ No/ Maybe*
- Participating in a support group to discuss mutual concerns, feelings, etc? *No / Yes/ Maybe*
- Counseling for family members to assist them in coping with your illness? *No/ Yes/ Maybe*

Have you every used relaxation techniques (such as hypnosis or biofeedback)? *Yes/No*
Would you like to know about Guided Imagery, Visualization, Quantum Biofeed Therapy and Relaxation Training? *No/ Yes/ Maybe*

Some people wish to know as much as they can about their illness and to make their own decisions about their care. Others wish to know the basics and want their doctors to make appropriate choice. How do you feel? ____
____

What questions do you have regarding treatment? ______________________________
____
Would you like information on?

- Resources for educational materials in the hospital's CIRCLE Center *(videos, audio materials, etc.)?* ____
- Community resources, i.e. how to find help at home *(housekeeping, meal preparation, etc transportation, attendant/nursing care, etc* ____________________________________
- Financial resources, programs, etc. ____

How can we help you? ____