



CANCER HISTORY (for cancer patients only)

Name: _____ Date: _____

Have you ever been diagnosed with pre-cancer, cancer, a mass or a tumor? Yes No

If yes, please give details below:

Type of Cancer	Date	Location(s) of cancer cells, mass or tumor	Stage

Oncologist: _____ Surgeon: _____
 Radiation Oncologist: _____ Other Physicians/(Specialty) _____

TUMOR MARKERS

Estrogen Positive Progesterone Positive Her2 neu Positive Triple Negative
 HPV Positive Gleason Score Other: _____

CURRENT STATUS

Recently Diagnosed: _____ Date: _____
 Surgery Date: _____ Describe: _____
 Recurrence/Date/Locations: _____
 Metastasis/Date/Locations: _____
 Current Stage: _____

CONVENTIONAL ONCOLOGY TREATMENT

Chemotherapy: Current Past Date(s): _____
 Drugs Used _____
 Schedule _____ For how many weeks/months? _____

Radiation Therapy: Current Past Location _____
 Type of Radiation Therapy _____
 Schedule _____ For how many weeks/months? _____

Hormone Therapy: Current Past Drugs/Hormones Used _____
 Date Started? _____ Date Discontinued _____

Other Medications: _____

Have you had any blood transfusions? Yes No If yes, how many? _____

SIDE EFFECTS	Yes		No	If yes, please check past or current:			
	Past	Current		Past	Current	Past	Current
Anemia			Change in Weight			Constipation	
Diarrhea			Difficulty eating or swallowing			Difficulty performing tasks of daily living	
Dizziness							
Hair Loss			Dry Mouth			Fatigue	
Insomnia			Hot Flashes			Infection	
Kidney damage			Itching			Joint Pain	
Lymphedema			Liver enzymes			Loss of Appetite	
Nausea			Mood Change			Mouth Sores	
Rash			Nerve pain or damage			Pain/ location_____	
Vomiting			Scar tissue			Numbness/location_____	
						Swelling/Location_____	

DIAGNOSTIC				
	Date of Most Recent		Date of Most Recent	Date of Most Recent
Mammogram		Breast MRI		Breast Ultrasound
Bone Density		Other MRI		Other Ultrasound
CT Scan/PET Scan		X-ray		Blood Test
Biopsy		Thermography		Prostate Exam
Other_____				

OTHER TREATMENTS, THERAPY AND ACTIVITIES			
Acupuncture	Glutathione	Psychotherapy/Counseling	
Herbal Medicines	Insulin	Support Group	
Nutritional Supplements	Hyperthermia	Prayer	
Homeopathy	Massage	Meditation	
Special Diet	Yoga	Visualization	
Detox/Cleanse	Exercise	Art Therapy	
IV Vitamins	Other_____		

How are you feeling emotionally?

Do you have a good support system?

Anything else you would like to share or include? Any specific concerns or questions you would like to discuss?