

**Cancer Patient Medical Questionnaire**

*Please fill out this medical form to further evaluate your case and design your treatment plan. It will be sent to you via email once you book your treatment appointment. This information is strictly confidential and will not be shared with third parties.*

**Diagnosis**

|  |  |  |  |
| --- | --- | --- | --- |
| Type of cancer: |  | Current stage: |  |
| Date of diagnosis: | 1st:  2nd:  3rd: | Stage at diagnosis: |  |
| Has it metastasized? |  | If yes, where? |  |

**History of Treatment (past and current)**

|  |  |
| --- | --- |
| Treatments taken (include date if possible): |  |
| Results from treatments: |  |
| Upcoming or scheduled treatments: |  |

**Medications**

|  |  |
| --- | --- |
| List the medications that you are currently taking: |  |

**Symptoms and Current Physical Condition**

|  |  |  |  |
| --- | --- | --- | --- |
| Normal Weight: |  | Current Weight? |  |
| Do you have nausea? |  | Are you experiencing vomit? |  |
| Describe your appetite:  (good, fair, bad, none) |  | How many meals do you have per day? |  |
| Do you have difficulty swallowing? |  | Do you have regular bowel movements? |  |
| Do you have a feeding tube? |  | Do you have a colostomy bag? |  |
| Do you have difficulty walking? |  | Do you use a walker, cane, or a wheelchair? |  |
| Do you have difficulty breathing? |  | Do you require oxygen? |  |
| Are you anemic? |  | Are you jaundice? |  |
| Are you bleeding?  If yes, what location? |  | Have you had a blood transfusion recently? |  |
| Are you in pain? |  | If yes, rate the pain on a scale 1 to 10. |  |

In addition to this medical questionnaire make sure you send us information like:

1. Pathology report (as many as you have)
2. All lab works
3. All imaging tests

If you have any questions or concerns, do not hesitate to contact us via email [shiningstarhc@gmail.com](mailto:shiningstarhc@gmail.com) or phone number +501 672-3536 / 670-3536.