Patient Information

First name:					
Last Name:					
Middle Sex:		M	○	F	○
E-mail:		Date of birth:			
Height:		Day Phone:			
Weight:		Evening Phone:			
Fax:		Apt. #			
Address:					
City:					
Zip/Postal code:		State/Province:			
Citizenship:		Country:			

Next of Kin Information

Next of Kin:		Relationship:	
Address:		Zip/Postal code:	
City:		State/Province	
Country:		E-mail:	
Day Phone:		Fax:	
Evening Phone:		(Country Code/Area Code/Number)	

Last Medical Examination

Doctor:		Date:	
Cancer Type:		Cancer Stage:	
Cancer sites:		At date:	
Prognosis:		Treatment Advised:	
Treatment Taken:			

Primary Care Doctor

Doctor:		State/Province:	
Zip/Postal code:		Suite/Room:	
City:		Tel.:	
Country:		State/Province:	
Email or fax:			

Cancer Specialist

Doctor:		Address:	
City:		Suite/Room:	
Zip/Postal code:		State/Province:	
Country:		Tel.:	
Email or Fax:		Address:	

Additional Health Information Please Answer All Questions

1. Any heart conditions?	Yes	◯	No	◯	
If yes describe:					
2. Heart Attack	Yes	◯	No	◯	
No - When?					
3. Hepatitis	Yes	◯	No	◯	
No –Type?					
4. Hypertension	Yes	◯	No	◯	
5. Diabetes	Yes	◯	No	◯	
6. Asthma	Yes	◯	No	◯	
7. Emphysema	Yes	◯	No	◯	
8. HIV	Yes	◯	No	◯	
Last CD4 Count					
Opportunistic infections?	Yes	◯	No	◯	
9. Glaucoma	Yes	◯	No	◯	
10. Pancreatitis	Yes	◯	No	◯	
11. Kidney Problems	Yes	◯	No	◯	
If Yes describe:					

12. Any other medical problems?		Yes	◯	No	◯	
If Yes describe:						

13. Do you have:	Pacemaker		○		
	Catheter		○		
	Colostomy		○		
	Artificial joint replacement		○		
	Other prosthesis		○		
14. Do you use:	Wheelchair		○		
	Walker		○		
	Oxygen		○		
	Other medical appliance		○		
15. Does your Doctor say you can travel?		Yes	○	No	○
16. Do you have a CEA or other tumor marker (PSA or AMAS)test less than 30 days old?		Yes	○	No	○
Date:					
Result:					
17. Have you had a CT Scan or MRI?		Yes	○	No	○
Date of CT Scan:					
Date of MRI:					
18. Please mark any of the following symptoms which apply to you:					
Chest pain	☐				
Shortness of breath	☐				
Fever	☐				
Chills	☐				
Sweats	☐				
Dizziness	☐				
Weight Loss	☐	How much?			
		How long?			
Cough (dry or productive)	☐				
Fatigue	☐				
Loss of appetite	☐				
Fatigue	☐				

Palpitations	☐				
Diarrhea	☐				
Constipation	☐				
Difficulty breathing following exertion (dyspnea)	☐				
Seizures	☐				
Any other present or recent complaints	☐				
19. Allergies to foods or drugs?		Yes	◯	No	◯
If yes describe					
20. Do you presently smoke?		Yes	◯	No	◯
Have you ever smoked?		Yes	◯	No	◯
Have you ever smoked?					
How much?					
When did you quit?					
21. Do you currently drink alcohol?		Yes	◯	No	◯
Have you ever?		Yes	◯	No	◯
How long?					
How much?					
When did you quit?					
22. Do you have any bleeding problems?		Yes	◯	No	◯
If yes describe					
23. Any Surgery?		Yes	◯	No	◯
What type of surgery?				Date	

24. Have you used steroids such as Prednisone?		Yes	◯	No	◯
How Much?					
How Long?					
When did you stop?					
How Much?					
How Long?					
25. Please list all medications you are taking or have recently stopped taking:					

Medication:	Dose:	When Started:	When stopped:
26. Describe any special diet you currently follow or have recently followed:			
27. Describe any supplement you now take or have recently stopped taking:			
28. Did you receive any Chemotherapy within the last 60 days?		Yes ◯	No ◯
29. Please note any other information, which may help our staff evaluate your case.			

YOU MUST BRING WITH YOU THE MOST RECENTLY AVAILABLE: CONFIRMED DIAGNOSIS, RADIOLOGY, PATHOLOGY, HISTOLOGY, CBC REPORTS.
A patient who arrives at a Clinic without a confirmed diagnosis signed by an oncologist will not be treated until the diagnosis is obtained from the patient's doctor.

How did you hear of Vidamas?			
Another Patient	○		
Friend or family member	○		
Other:	○	Source's name:	
		Source's Tel.:	
		Source's Address:	

Patient Name: _____

Date: _____

RESET FORM

SEND