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: ____________________