Instructions: Please complete the sections below to the best of your knowledge. You may leave a section blank if you do not have the information requested.

General Information

Patient Name:	**Date of Birth:**
Cell Phone: **Home Phone:**	**Email:**

Health Care Providers (Names, Institution, Contact Info)

Primary Care Provider/ Internist:	
Surgeon:	
Radiation Oncologist:	
Medical Oncologist:	
Integrative Cancer Care Coordinator:	

Other Health Providers: (Acupuncturist, Nutritionist, Naturopathic Doctor, Physical Therapist, Chiropractor, Urologist, Nurse Practitioner, Gynecologist, Psychologist, etc)

Name	Specialty	Location	Phone

Co-Morbid or Concurrent Risk Factors & Health Issues

	Insulin Res / Pre-Diabetes		Depression		Dysbiosis		Allergies
	Diabetes, Type:		Anxiety		GERD		Asthma
	Overweight		Mental Illness		SIBO		Food/Gluten Sensitivities
	Heart Disease		Alcoholism		IBS		Sinus Problems
	Unhealthy Cholesterol		Drug Use / Abuse		Gastritis		Toxic Exposures
	High Blood Pressure		Smoking/Tobacco Use		Leaky Gut Syndrome		Heavy Metals
	Blood Clotting/Coagulation		Chronic Fatigue		Sleep Cycle Disorder		Organic Pollutants
	Kidney Disease		Chronic Headaches		Chronic Pain		Mold
	Autoimmune Disease:		Other Addiction(s):		Gastrointestinal-Digestive Disease		Other:

Special Diets - Current

	Avoid Gluten		Avoid Sugar		High Protein Diet		Anti-inflammatory Diet
	Avoid Wheat		Avoid Artificial Sweetener		Low Protein Diet		Detox
	Avoid Corn		Avoid Red Meat		High Fiber Diet		Elimination Diet
	Avoid Dairy		Vegetarian Diet		Low Fiber Diet		Hallal
	Avoid Eggs		Vegan Diet		Raw Food Diet		Kosher
	Avoid Soy		Low Glycemic/Carb Diet		Low Allergen Diet		Other:

Organic, whole, unprocessed, fresh, chemical-free and hormone-free without artificial colors, flavors or preservatives

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Diagnosis

Pathology – Histology: Cancer Type/Location/Histology Subtype □ ER+ □ PR+ □ Her2neu+ □ Gleason Score	**Diagnosis Date** (year): **Recurrence**: □ Yes □ No
Stage: □ I □ II □ III □ Other: □ Not applicable	**Grade:** **Ki67:**
Tumor Analysis: Molecular & Genetic Markers (Caris, Foundation One, Other Tumor Profiles)	
Radiology: Scans MRIs (Date / Findings / Recurrence?)	

Treatment

Surgery Yes No	**Year**	**Location**	**Procedure**	**Findings**

Radiation Yes No	**Location**	**End Date (year)**
Systemic Therapy Yes No (chemo, hormonal, other)	**Agents Used**	**Current OR End Date (year)**

Side Effects – Adverse Effects

Current & Persistent Symptoms (Types, Onset, Duration)

Complementary, Natural & Alternative Treatments (Check if used prior, "I" if patient wants more information)

	Acupuncture/Chinese Med.		Pain Management		Detoxification		Gluten Free Diet
	Naturopathic Medicine		Meditation		Fasting		Dairy Free Diet
	Nutritional Supplements		Prayer		Enemas		Raw Food Diet
	Herbal Medicine		Yoga		Colonic Therapy		Special Diet – Other
	Homeopathy		Tai Chi		Saunas & Sweating		Massage / Body Work
	Chiropractic		Relaxation / Stress Mng		Vegetarian Diet		Vaccine Therapy
	Physical Therapy		Reiki / Energy Medicine		Vegan Diet		Treatment Outside U.S.
	Other:						

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