IMPORTANT: This questionnaire should be filled out completely. Send this form along with the other items listed on the program checklist on page 2 to People Against Cancer.

Medical History Questionnaire

People Against Cancer

604 East Street • P.O. Box 10 • Otho, Iowa 50569
Phone: 515-972-4444 • Fax: 515-972-4415
info@PeopleAgainstCancer.com • www.PeopleAgainstCancer.com

DATE ____________

PLEASE PRINT CLEARLY OR TYPE! Use separate sheet if more space is necessary for any section.

Patient Name ____________

Address ____________

City ____________ State ____________ Zip ____________

Phone (home) ____________

Phone (work) ____________

Referred By ____________

Social Security Number ____________

☐ Male ☐ Female Date of Birth ____________ Age ____________

Height ____________ Normal Weight ____________ Present Weight ____________

Caller Name ____________

Relationship to Patient ____________

Address ____________

City ____________ State ____________ Zip ____________

Phone ____________

Section 1 Original Cancer Diagnosis

Original Cancer Type ____________

Original Cancer Location ____________

Date Diagnosed ____________

Type/Grade ____________ Stage ____________

Hospital/Clinic/Office ____________

Metastases or Recurrence Location ____________

Date Diagnosed ____________

Details ____________

Section 2 Surgery

Surgery ☐ Yes ☐ No Date ____________

Surgeon ____________

Hospital/Clinic Office ____________

Additional Surgery ____________

Section 3 Chemotherapy

Chemotherapy ☐ Yes ☐ No

Type of Chemotherapy ____________

Oncologist ____________

Hospital/Clinic/Office ____________

Date Initiated ____________ Date Completed ____________

Number of Treatments ____________

Additional Chemotherapy ____________

Section 4 Radiation

Radiation ☐ Yes ☐ No

Radiation Absorbed Dose (RADS) or Centagrays (Cyg) ____________

Radiologist ____________

Date Initiated ____________ Date Completed ____________

Section 5 Other Therapies

Other Therapies/Drugs/Medications (past) ____________

Other Therapies/Drugs/Medications (current) ____________

Vitamins ☐ Yes ☐ No Details ____________

Diet ____________

Physician ____________

Section 6 Present Condition

Karnofsky Rating (see below) ____________

Karnofsky Rating Scale:

Score	Criteria (circle and insert above)
100	Normal; no complaints; no evidence of disease
90	Able to carry on normal activity; minor symptoms of disease
80	Normal activity with effort; some symptoms of disease
70	Cares for self; unable to carry on normal activity or active work
60	Requires occasional assistance but is able to care for needs
50	Requires considerable assistance and frequent medical care
40	Disabled; requires special care and assistance
30	Severely disabled; hospitalization is indicated death not imminent
20	Very sick; hospitalization necessary; active treatment is necessary
10	Moribund, fatal processes progressing rapidly
0	Dead

Appetite ____________ Constipated ____________

Jaundiced ____________ Pain ____________

Bleeding ____________ Fluid ____________

Anemia ____________ Patient Attitude ____________

Mercury Amalgam (silver) Dental Fillings ☐ Yes ☐ No How many? ____________

Root Canals ☐ Yes ☐ No How many? ____________

Other Dental Problems ____________

General Comments ____________