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sagecancercare.com

Thank you for taking the time to complete this form. Your answers will greatly assist our doctors in providing you the best care possible. All information is confidential.

Name: _____ Date of Birth: _____ Gender: _____

Address: _____

Cell Phone: _____ Home Phone: _____

Preferred contact number: ☐ Cell ☐ Home ☐ Other: _____

Email: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

How did you hear about Sage Cancer Care? _____

Sage Cancer Care will occasionally need to call patients and we wish to ensure your privacy regarding your treatment at our clinic. If we are unable to reach you by phone, please indicate where it is appropriate to leave voice messages for you (check all that apply):

☐ Phone answering machine ☐ With family members ☐ At Work ☐ Never leave messages

Is this your first visit to a naturopathic doctor? ☐ Yes ☐ No

What do you hope to get out of your visit today?

_____

_____

What are your most important health concerns or symptoms? Please list in order of importance.

1. _____
2. _____
3. _____
4. _____

Cancer Diagnosis and Treatment History

Please fill out this section as accurately as possible. Leave blank any questions that do not apply.

Date of initial diagnosis: _____ Type of tumor: _____

Current status (check one): ☐ Remission ☐ Active

Cancer treatment history and your health care team:

Surgery type and date: _____

_____

Surgeon: _____ Clinic/Hospital: _____

Radiation therapy type and date range: _____

_____

Radiation oncologist: _____ Clinic/Hospital: _____

Chemotherapy treatment types and date range: _____

_____

Medical oncologist: _____ Clinic/Hospital: _____

Additional health care providers (including integrative and alternative) working with you:

Primary care: _____ Clinic/Hospital: _____

Name: _____ Clinic/Hospital: _____

Name: _____ Clinic/Hospital: _____

Name: _____ Clinic/Hospital: _____

Do you have a family history of cancer? ☐ Yes ☐ No ☐ Unsure

If yes, please list relationship to you and type of cancer:

Relationship	Type of Cancer

General Health Information

Height: _____ Weight: _____ Weight 1 year ago: _____ Max weight: _____ When: _____

Occupation: _____ Currently working (hours per week): _____

Primary interests and hobbies: _____

Primary form of exercise, if any: _____ How often: _____

Allergies

Do you have an allergy to any of the following? List specific allergies and describe your reaction.

Drugs: _____

Foods: _____

Chemicals/Perfumes: _____

Animals: _____

Medications and Supplements

Please list any prescriptions, OTC medications, or supplements that you currently take.

Medication/Supplement Name	Dose	Frequency

(continue on last page if necessary)

Medical History

Do you have a personal history of any of the following conditions (check box if yes)?

☐ Autoimmune	☐ Asthma/COPD	☐ Heart disease	☐ Multiple sclerosis
☐ Anemia	☐ Crohn's/Colitis	☐ Hypertension	☐ Osteoporosis
☐ Anxiety disorder	☐ Depression	☐ IBS	☐ Stroke
☐ Arthritis	☐ Diabetes	☐ Kidney disease	☐ Other (see below)

Please list any other significant medical conditions here:

_____

Diet and Lifestyle

24-hour diet recall (please list all food and drink you have had in the past 24 hours):

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Please check "Yes" or "No" for the following questions:

	Yes	No		Yes	No
Get 6-8 hours of sleep nightly?			Drink alcohol?		
Sleep well?			Use tobacco? Number of packs daily: _____ Number of years: _____		
Wake feeling rested?			Enjoy your work?		
In a supportive relationship?			Take vacations?		
History of abuse?			Spend time outside?		
Major life trauma (past 3 years)?			Eat 3 meals daily?		
Use recreational drugs?			Drink soda/cola regularly?		

Assessing the Areas of Your Life

In assessing your health, it is helpful to have some sense of the degree of satisfaction you feel in various areas of your life. For each category below, please rate your satisfaction on a scale of 1 to 10, with 10 being completely satisfied (check appropriate number for each category).

	0	1	2	3	4	5	6	7	8	9	10
Friends and Family											
Living Environment											
Health											
Career											
Relationships/Romance											
Recreation											
Money											
Personal Growth/Spirituality											

Review of Systems

In this section, check the box if you have the symptom currently or if you have experienced it in the past 6 months. Some are yes/no questions, in which case check the box to indicate "yes."

Constitutional	
Fever	
Night Sweats	
Weight gain	
Weight loss	
Fatigue	
Eyes, Ears, Nose, and Throat	
Eye pain	
Double vision	
Blurred vision	
Vision loss	
Ear pain	
Hearing loss	
Tinnitus	
Nasal bleeding	
Nasal discharge	
Sinus pressure	
Sore throat	
Mouth sores	
Taste changes	
Difficulty swallowing	
Bleeding gums	
Hoarseness	
Neck pain	

Cardiovascular	
Chest pain	
Palpitations	
Peripheral edema	
Varicose veins	
Leg pain with walking	
Respiratory	
Cough	
Wheezing	
Shortness of breath	
Snoring	
Gastrointestinal	
Nausea	
Vomiting	
Diarrhea	
Constipation	
Abdominal pain	
Heartburn	
Blood in stools	
Stool incontinence	
Skin	
Rash	
Hives	
Recent skin changes	

Genitourinary	
Pelvic pain	
Burning with urination	
Frequency	
Urgency	
Blood in urine	
Incontinence	
Change in libido	
Male Reproductive	
Testicular pain	
Erectile dysfunction	
Female Reproductive and Breast	
Postmenopausal	
Abnormal vaginal bleeding	
Heavy bleeding	
Painful menses	
Vaginal discharge	
Vaginal dryness	
Vaginal itching or burning	
Pain with sex	
Breast pain	
Breast lump	
Nipple discharge	

Musculoskeletal	
Bone pain	
Joint pain	
Muscle pain	
Neurologic	
Headache	
Muscle weakness	
Numbness and tingling	
Nerve pain	
Memory loss	
Difficulty concentrating	
Seizure	
Dizziness	
Psychiatric	
Depression	
Anxiety	
Irritability	
Mood swings	
Insomnia	
Hematologic and Immune	
Lymph node enlargement	
Easy bruising and bleeding	
Frequent colds	

Do you have any other health concerns that have not been covered in this questionnaire?

_____

_____

_____

_____