



MEDICAL QUESTIONNAIRE

Please use Nuance PDF Viewer (free) in order to fill and save this form:
<http://www.nuance.com/for-business/by-product/pdf/pdfreader/index.htm>

Adobe PDF Reader (free) can also be used, but it does not allow saving the filled form.
It only allows printing of the filled form: <http://get2.adobe.com/reader/>

PERSONAL INFORMATION	
First Name: _____	Last Name: _____
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Title: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> Other _____	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Wid. <input type="checkbox"/> Other _____	
Street: _____	Unit # _____
City: _____	State/Prov: _____ Country: _____
Postal Code: _____	
Home phone: _____	Work Phone: _____
Cell phone: _____	Fax number: _____
5. Email address: _____	
6. Date of birth: (day/month/year) _____	
7. Health card number: _____ VC: _____ Health card province: _____ (for Canadian patients only)	
8. Do you have private health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	
9. Who should be contacted in case of emergency?	
Name: _____	Relationship: _____
Contact numbers: _____	
10. Second language (optional): _____	
11. Religion (optional): _____	

CANCER HISTORY

What type of cancer do you have?

How was it diagnosed?

Diagnosis date:

Was a biopsy obtained? Yes No Not sure

What treatments have you received?

Chemotherapy Yes No Not yet, starting soon Not sure

Radiation therapy Yes No Not yet, starting soon Not sure

Surgery Yes No Not yet, starting soon Not sure

Experimental therapy Yes No Not yet, starting soon Not sure

Natural therapy Yes No Not yet, starting soon Not sure

PAST MEDICAL HISTORY

Do you have (or have you ever had) any of the following? *(check only if yes)*

Disease		√	About when was it diagnosed?
Cardiovascular disease	High blood pressure	<input type="checkbox"/>	
	Angina	<input type="checkbox"/>	
	Heart attack	<input type="checkbox"/>	
	Congestive heart failure	<input type="checkbox"/>	
	Abnormal heart rhythm	<input type="checkbox"/>	
	Blood clot (DVT)	<input type="checkbox"/>	
	Other: specify	<input type="checkbox"/>	
Lung disease	Asthma	<input type="checkbox"/>	
	Bronchitis/Pneumonia	<input type="checkbox"/>	
	Emphysema	<input type="checkbox"/>	
	Other: specify	<input type="checkbox"/>	
Kidney disease	Stones	<input type="checkbox"/>	
	Infections	<input type="checkbox"/>	
	Kidney failure	<input type="checkbox"/>	
	Other: specify	<input type="checkbox"/>	
Liver disease	Hepatitis	<input type="checkbox"/>	
	Jaundice	<input type="checkbox"/>	
	Other: specify	<input type="checkbox"/>	
Blood disorder	Bleeding problems	<input type="checkbox"/>	
	Anemia	<input type="checkbox"/>	
	Other: specify	<input type="checkbox"/>	
Neurological problems	Stroke	<input type="checkbox"/>	
	Seizures	<input type="checkbox"/>	
	Other: specify	<input type="checkbox"/>	

ALLERGIES / ADVERSE REACTIONS

Do you have an **allergy** or have you ever had an **adverse reaction** to any of the following?

Category	Yes √	No √	Please list
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	
Foods	<input type="checkbox"/>	<input type="checkbox"/>	
Others (pollen, grass, pets, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	

FAMILY HISTORY

Please provide the following information regarding blood relatives

Relation	List major illness (e.g. diabetes, cancer, ulcers, blood clots, heart, lung, liver, kidney disease)
Father	
Mother	
Sisters	
Brothers	
Children	
Other	

ECOG PERFORMANCE STATUS

Please indicate your level of activity (check one)	√
Fully active, able to carry on all activities (same as before cancer diagnosis) without restriction.	<input type="checkbox"/> 0
Restricted in strenuous activity but walking and able to carry out light work e.g. office work.	<input type="checkbox"/> 1
Walking and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of the day.	<input type="checkbox"/> 2
Capable of only limited self-care (washing, changing clothes, going to washroom), confined to bed or chair more than 50% of the day.	<input type="checkbox"/> 3
Completely disabled. Cannot carry on any self-care (washing, changing clothes, going to washroom). Totally confined to bed or chair.	<input type="checkbox"/> 4

FUNCTIONAL ENQUIRY

Current body weight: pounds kg Height:

Weight Decreasing Stable Increasing

Appetite Decreased Normal Increased

Sleep Decreased Normal Increased

Mood Depressed Normal

Energy level Low Normal High

Do you have any of the following: (0=none, 10=worst)

Fever 0 1 2 3 4 5 6 7 8 9 10

Chills 0 1 2 3 4 5 6 7 8 9 10

Sweating 0 1 2 3 4 5 6 7 8 9 10

Mouth sores 0 1 2 3 4 5 6 7 8 9 10

Nausea 0 1 2 3 4 5 6 7 8 9 10

Vomiting 0 1 2 3 4 5 6 7 8 9 10

Food sticking when swallowing 0 1 2 3 4 5 6 7 8 9 10

Pain when swallowing 0 1 2 3 4 5 6 7 8 9 10

Constipation 0 1 2 3 4 5 6 7 8 9 10

Diarrhea 0 1 2 3 4 5 6 7 8 9 10

Cough 0 1 2 3 4 5 6 7 8 9 10

Shortness of breath 0 1 2 3 4 5 6 7 8 9 10

Dizziness 0 1 2 3 4 5 6 7 8 9 10

Palpitations (feeling of abnormal heartbeat) 0 1 2 3 4 5 6 7 8 9 10

Limb swelling legs arms 0 1 2 3 4 5 6 7 8 9 10

Facial swelling 0 1 2 3 4 5 6 7 8 9 10

Headache 0 1 2 3 4 5 6 7 8 9 10

Numbness / tingling
If yes, what parts of the body? _____

Restlessness 0 1 2 3 4 5 6 7 8 9 10

Confusion / memory problems 0 1 2 3 4 5 6 7 8 9 10

Rash 0 1 2 3 4 5 6 7 8 9 10

Bleeding problems / easy bruising 0 1 2 3 4 5 6 7 8 9 10

Urination problems 0 1 2 3 4 5 6 7 8 9 10

Pain
If yes, what parts of the body? _____

MISCELLANEOUS

Is any "conventional" cancer treatment being offered now? Yes No

Are you or do you think you may be pregnant? Not applicable Yes No

Are you receiving nursing care at home? Yes No Not sure

Do you have a "power of attorney" for:

Personal care? Yes (name: _____) No Not sure

Finances? Yes (name: _____) No Not sure

HEALTH CARE INFORMATION

Please provide the following information about your health care providers:

Specialty	Name	Phone Number	Hospital
Family doctor			
Oncologist			
Radiation oncologist			
Surgeon			
Other			

Please provide the name(s) of the hospital(s) you most often deal with:

MEDICOR

As per Medicor Cancer Centres Privacy Policy, we do not give confidential personal information over the phone. If such a request is made, we may require correct answers to some questions before giving out any information. This is only for your protection. In order to do this, please provide answers to **any two of the following** questions:

a. Place of birth _____

b. Mother's name _____

c. Name of pet _____

d. Favourite colour _____

How did you find out about Medicor Cancer Centres?

Thank you for providing this information.

Health Number/Numéro de carte Santé									

Health Number Release

Divulguation du numéro de carte Santé

THIS PAGE IS FOR CANADIAN PATIENTS WHO ARE COMING TO THE MEDICOR OFFICE FOR IN-PERSON CONSULTATION ONLY (EXCEPT QUEBEC)

Confidential when completed/Renseignements confidentiels

1

Patient/Patiente

A. General Information/Renseignements généraux

Last name/Nom de famille						First name/Prénom							
Middle name/Deuxième prénom				Sex/Sexe		Birth date/Date de naissance				month/mois		day/jour	
				<input type="checkbox"/> M <input type="checkbox"/> F		year/année							

If an alternate last name is known, please provide/Si vous avez un deuxième nom de famille, inscrivez ici

B. Health Number Disclosure/Divulguation du numéro de carte Santé

The Ministry of Health and Long-Term Care will give your Health Number to the health care provider/facility.

Le ministère de la Santé et des Soins de longue durée donnera votre numéro de carte Santé au fournisseur/à la fournisseuse ou à l'établissement de soins de santé.

I agree to allow the Ministry of Health and Long-Term Care to release my Health Number to the health care provider/facility listed below.

J'autorise le ministère de la Santé et des Soins de longue durée à divulguer mon numéro de carte Santé au fournisseur ou à l'établissement de soins de santé dont le nom figure ci-dessous.

Signature of patient or guardian Signature du patient ou du tuteur		Date	Home phone number Téléphone (domicile)		Business phone number Téléphone (bureau)	
			() -		() -	

A parent or guardian may sign for a child under 16 years of age. A person holding power of attorney may sign for the represented individual. Le père, la mère ou le tuteur, la tutrice peuvent signer pour un enfant de moins de 16 ans. Une personne titulaire d'une procuration peut signer pour la personne qu'elle représente.

2

Provider/Facility Fournisseur/Fournisseuse/Établissement

Date of service/Date de prestation du service		
year/année	month/mois	day/jour

Provider no./N° du fournisseur	Provider's phone number N° de téléphone du fournisseur
	() -

Facility no./N° de l'établissement	Facility phone number N° de téléphone de l'établissement
	() -

The Health Number of the patient will be returned to the provider/facility listed here.

Le numéro de carte Santé du patient/de la patiente sera transmis au fournisseur/à la fournisseuse/à l'établissement de soins de santé dont le nom figure ci-dessous.

Provider name and address/Nom et adresse du fournisseur

Facility name and address/Nom et adresse de l'établissement

Collection of the information on this form is for the assessment and verification of eligibility for Health Insurance and Drug Benefit and administration of the Health Insurance and Ontario Drug Benefit Acts, and for health planning and coordination. It is collected/used for these purposes under the authority of the Ministry of Health Act, section 6(1,2), Health Insurance Act, section 4(2) (b,f), 10, 11(1), and Regulation 201/96 under the Ontario Drug Benefit Act, section 2. For information about collection practices, call 1 800 268-1154, in Toronto (416) 314-5518, or write to the Director, Registration and Claims Branch, P.O. Box 48, 49 Place d'Armes, Kingston ON K7L 5J3.

Les renseignements demandés dans cette formule sont réunis aux fins d'évaluation et de vérification de l'admissibilité à l'assurance-santé et aux prestations de médicaments gratuits, aux fins d'administration de la Loi sur l'assurance-santé et de la Loi de 1986 sur le régime de médicaments gratuits de l'Ontario, et aux fins de planification et de coordination des services de santé. Ces renseignements sont réunis ou utilisés à ces fins en vertu de la Loi sur le ministère de la Santé, paragraphes 6(1), (2), de la Loi sur l'assurance-santé, alinéas 4(2)(b), f), article 10, paragraphe 11(1), et du Règlement 201/96 pris en application de la Loi de 1986 sur le régime de médicaments gratuits de l'Ontario, paragraphe 2. Pour plus de précisions sur la collecte de ces renseignements, faites le 1 800 268-1154 ou, à Toronto, le (416) 314-5518, ou écrivez au directeur ou à la directrice de l'inscription et des demandes de règlement, C.P. 48, 49, Place d'Armes, Kingston ON K7L 5J3.