



## 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.**



## Governing Law and Jurisdiction Agreement

I hereby agree that:

- a) all aspects of the relationship between me and Medicor Cancer Centres Inc., as well as its agents, delegates, employees, and any physicians and other independent health care practitioners providing medical or other health care and treatment to me, or in association with Medicor Cancer Centres Inc., including without limitation any medical or other health care and treatment provided to me, and
- b) the resolution of any and all disputes arising from or in connection with that relationship, including any disputes arising under or in connection with this Agreement,

shall be governed by and construed in accordance with the laws of the Province of Ontario and the laws of Canada applicable therein.

I hereby acknowledge that the medical or other health care and treatment I receive from Medicor Cancer Centres Inc. will be provided in the Province of Ontario, and that the Courts of the Province of Ontario shall have exclusive jurisdiction to hear any complaint, demand, claim, proceeding or cause of action, whatsoever arising from or in connection with that medical or other health care and treatment, or from any other aspect of my relationship to Medicor Cancer Centres Inc.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient (Please print)

X  
\_\_\_\_\_  
Signature of Patient or  
Substitute decision-maker on behalf of patient