Cancer Support Sonoma
Healing. Caring. Community.

Patient Information Form

Name_____ Date_____

Address_____

Home Phone Number_____Cell Phone Number_____

Can we leave a message? (Circle one) Yes No

E-mail_____Date of Birth_____

Emergency Contact: Name_____Phone_____

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Type of Cancer_____Stage_____ Grade _____ Date of Diagnosis _____

If Breast Cancer, which breast? (circle) Left Right

Recurrence (circle one) Yes No If yes, original diagnosis date_____

Metastasis (circle one) Yes No If yes, site of metastasis_____

Surgery(s) (circle one) Yes No If yes, dates_____

Chemotherapy (circle one) Yes No If yes, dates_____

Radiation (circle one) Yes No If yes, dates_____

Have you had any nodes removed or radiated? (circle one) Yes No

If yes, site(s)_____

Have/do you had lymphedema? (circle one) Yes No

If yes, please describe (site, severity, frequency)

_____

Do you have any medical devices? (circle one) Yes No If yes, please describe

_____

Other treatments_____

_____

Primary Care Doctor_____

Oncologist_____Radiologist_____

Surgeon_____Other_____

Who is your health insurance provider?_____

Complementary and Alternative Therapies (past or current)

Modality_____Provider_____ Date_____

Modality_____Provider_____ Date_____

Modality_____Provider_____ Date_____

Modality_____Provider_____ Date_____

Other diagnosis and health issues_____

_____

_____

Medications, Herbs, Supplements (including doses and frequency)

_____ _____

_____ _____

_____ _____

_____ _____

Approximately how many hours of sleep to you get each night? _____

Give an example of your diet on an average day:

Breakfast_____ Time_____

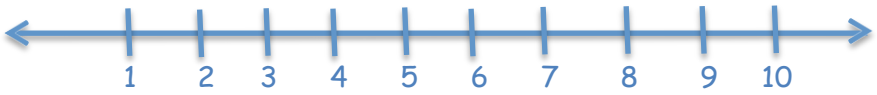
Snack_____ Time_____

Lunch_____ Time_____

Snack_____ Time_____

Dinner_____ Time_____

Stress level on a scale of 1-10, 1 = no stress in my life at all, 10 = High stress all the time



What is your biggest source of stress in addition to your health situation?

_____

_____

What do you do to take care of yourself?_____

How often do you do this?_____

What relaxes you?_____

How often do you do this?_____

Do you do some form of exercise/movement? (Circle one) Yes No

Type?_____How often? _____

I am (Circle) Married Separated Divorced Widowed Single Domestic partnership

Name of Spouse/Partner_____

Briefly describe your support system (friends, family, other forms of support)

Spiritual/religious affiliations_____

Anything else it would be helpful for our providers to know about you?