# PROSPECTIVE PATIENT FORM

Last Name: _____ First Name: _____ Middle Initial: _____

☐ Female ☐ Male Age: _____ Date of Birth: _____ Today's Date: _____

Phone Number: _____ Email Address:_____

City: _____ State: _____ Zip Code: _____

Who referred you to us? _____

What type of cancer do you have? _____

When were you first diagnosed? _____ What stage is the cancer? _____

What organs/tissues has it metastasized (spread) to? _____

What are the dates and results of your most recent scan (CT, MRI, PET) and/or tumor markers?

_____

_____

_____

What treatments and/or surgeries have you had for cancer thus far and what were the results?

_____

_____

_____

_____

What side effects are you experiencing from your current treatment?_____

_____

_____

Treatment Expectation: ☐ Achieve remission ☐ Only improve quality of life

Please answer each question below to the best your knowledge:

| Questions | Yes | No | Unsure |
|---|---|---|---|
| Do you have any mental, physical, or financial condition(s) that prevents adherence to a recommended treatment plan? | | | |
| Are you willing to incorporate conventional therapy when appropriate? | | | |
| Do you have compromised kidney and/or liver function? | | | |
| Do you have elevated iron levels? | | | |
| Do you have elevated inflammatory markers? | | | |
| Do you have severe anemia? | | | |
| Do you have a low albumin level? | | | |
| Do you have jaundice (yellow tint to the skin or eyes caused by elevated bilirubin)? | | | |
| Do you have severe cachexia (muscle wasting)? | | | |
| Do you have ascites (fluid in the abdomen), pleural effusion (fluid between the lungs and chest wall), and/or generalized swelling throughout the body? | | | |
| Are you experiencing uncontrollable pain and/or nausea? | | | |

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