

Preliminary Application Form

Patient Information

Patient First Name:	Patient Last Name:
Address:	Home Phone: () -
City:	Work Phone: () -
State:	Cell Phone: () -
Zip Code:	E-mail:
Date of Birth: / /	Age:

Emergency Contact

Contact 1 Name:	Relationship:
Address:	Home Phone: () -
City:	Work Phone: () -
State:	Cell Phone: () -
Zip Code:	E-mail:
Contact 2 Name:	Relationship:
Address:	Home Phone: () -
City:	Work Phone: () -
State:	Cell Phone: () -
Zip Code:	E-mail:

Health Information

The following questions tell us something about your general background and some basic information about your medical condition.

Allergies

Allergy 1:	Reaction:
Allergy 2:	Reaction:
Allergy 3:	Reaction:
Allergy 4:	Reaction:

Present Condition

Kamofsky Score:

Karnofsky Rating Scale

100 Normal; no complaints; no evidence of disease
 90 Able to carry on normal activity; minor symptoms of disease
 80 Normal Activity with effort
 70 Cares for self; unable to carry on normal activity or active work
 60 Requires occasional assistance but is able to care for needs
 50 Requires considerable assistance and frequent medical care
 40 Disabled; requires special care and assistance
 30 Severely disabled; hospitalization is indicated, death not imminent
 20 Very sick; hospitalization necessary; active treatment is necessary
 10 Moribund, fatal processes progressing rapidly
 0 Dead

Appetite:

Bowel Movement:

Urinary:

Jaundiced:

Pain:

Bleeding:

Fluid:

Anemia:

Fatigue:

Patient Attitude:

Sexual Activity:

Broken Bones:

Blood Pressure:

Original Cancer Diagnosis

**Original Cancer
Type:**

**Date Diagnosed
(Original Cancer):** / /

**Original Cancer
Location:**

Hospital/Clinic/Office:

Recurrence

Date Diagnosed / /

Location:

(Metastases):

Details:

Surgery

Surgery: Yes / No

Date: / /

Location:

Hospital/Clinic/Office:

Surgeon:

Results:

Complications:



Chemotherapy

Chemotherapy:	Yes / No	Date Initiated:	/ /
Type of Therapy:		Date Completed:	/ /
Oncologist:		Hospital/Clinic/Office:	
Number of Visits:		Results:	
Complications:			

Radiation

Radiation:	Yes / No	Date Initiated:	/ /
Radiologist:		Date Completed:	/ /
Radiation Absorbed Dose (RADS):		Hospital/Clinic/Office:	
Number of Visits:		Results:	
Complications:			

Other Therapies

Past:		Current:	
Therapy:		Therapy:	
Drug:		Drug:	
Medications		Medications	
Herbs:		Herbs:	
Complications:		Complications:	
Results:		Results:	
Vitamins:		Diet:	
Physician:		Hospital/Clinic/Office:	

Test Results

Name of Test: (CT Scan, MRI, X-Ray, etc.)	
Reasons for test:	
Results:	