

DrHernandez.com

Adjunctive Cancer Care

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PERSONAL

NAME _____ D.O.B. _____ TODAY'S DATE _____
STREET ADDRESS _____
CITY _____ STATE _____ COUNTRY _____ POSTAL CODE _____
HOME PHONE _____ CELL PHONE _____ EMAIL _____
MARITAL STATUS _____ HOW MANY YEARS _____ CHILDREN'S AGES _____
EMERGENCY CONTACT _____ RELATIONSHIP _____
PHONE _____
OCCUPATION _____ EMPLOYER _____ WORK PHONE _____
HOW DID YOU HEAR ABOUT US? _____
WOULD YOU LIKE TO RECEIVE OUR MONTHLY EMAIL NEWSLETTER? _____

CANCER HISTORY

CANCER DIAGNOSIS _____ DATE? _____
OTHER DIAGNOSES OR MAJOR MEDICAL CONCERNS? _____
HAS CANCER METASTICIZED? _____ TO WHAT SITE? _____
ARE YOU UNDER AN ONCOLOGIST'S CARE NOW? _____ PAST TREATMENT DATES OR CURRENT SCHEDULE:

NAME AND PHONE NUMBER OF ONCOLOGIST _____
DID YOUR TREATMENT INVOLVE SURGERY? _____ DID YOUR TREATMENT INVOLVE REMOVAL OF LYMPH NODES? _____
FROM WHAT SITE? _____
HAVE YOU RECEIVED RADIATION IN THE PAST? _____ DATES? _____
ARE YOU RECEIVING RADIATION NOW? _____ HOW MANY TREATMENTS? _____ DATES? _____
CHEMOTHERAPY DRUGS YOU HAVE RECEIVED _____
ARE YOU RECEIVING CHEMO NOW? _____
DO YOU HAVE A NEXT STEP IN YOUR TREATMENT PLAN? _____

CURRENT MEDICATIONS/DOSAGE

<u>NAME OF MEDICATION</u>	<u>DOSAGE</u>	<u>WHEN PRESCRIBED</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HAS CANCER OR CANCER TREATMENT AFFECTED ANY OF THE FOLLOWING FUNCTIONS IN YOUR BODY?

IF YES, PLEASE EXPLAIN.

___ LUNG ___ LIVER ___ NERVOUS SYSTEM ___ HEART ___ KIDNEY ___ BLOOD COUNTS ___

CURRENT ISSUES RELATED TO YOUR TREATMENT

___ LYMPHEDEMA ___ FRAGILE OR SENSITIVE SKIN ___ AREA OF PAIN OR BURNING ___ SURGICAL WOUNDS
___ OSTOMY ___ DIFFICULTY BREATHING ___ INFECTION ___ I.V. PORT ___ TUMOR PAIN ___ FRAGILE VEINS
___ DIFFICULTY MOVING ___ MEDICAL DEVICES _____

FAMILY HISTORY OF CANCER (Self (**Self**); Mother (**M**), Father (**F**); Siblings (**S or B**); grandparent (**GP**): LIST CANCER TYPE

GENERAL SIGNS AND SYMPTOMS. CHECK FOR YES; COMMENT ON YES ANSWERS AT END OF SECTION

___ RECENT FRACTURES OR INJURIES?	___ CONSTIPATION OR DIARRHEA?
___ RECENT SURGERY?	___ HORMONAL IMBALANCE?
___ BLEEDING PROBLEMS?	___ MENSTRUAL ISSUES?
___ SWELLING ANYWHERE IN BODY?	___ MENOPAUSAL ISSUES?
___ PAIN OR TENDERNESS ANYWHERE IN BODY?	___ SLEEP ISSUES?
___ NUMBNESS OR REDUCED SENSATION?	___ HIGH CHOLESTEROL?
___ INFLAMMATION?	___ SWOLLEN GLANDS?
___ SKIN RASHES OR ITCHING?	___ DIZZINESS OR LOSS OF BALANCE?
___ ALLERGIES OR SENSITIVITIES?	___ HEADACHES OR MIGRAINES?
___ CARDIOVASCULAR CONDITIONS?	___ DIFFICULTY SWALLOWING?
___ LIVER CONDITIONS?	___ URINARY FREQUENCY OR BURNING?
___ RESPIRATORY OR LUNG CONDITIONS?	___ INCONTINENCE?
___ WEIGHT LOSS?	___ ERECTILE DYSFUNCTION?
___ LOSS OF APPETITE?	___ MUSCLE WEAKNESS?
___ VISION CHANGES?	___ NEW BONE PAIN?
___ FEVER OR CHILLS?	___ MOUTH SORES?
___ DIABETES?	___ DEPRESSION?
___ THYROID PROBLEMS?	___ ANXIETY?
___ JOINT PAIN?	___ FATIGUE?
___ DIGESTIVE PROBLEMS?	___ HISTORY OF MENTAL ILLNESS?
___ GASTRIC REFLUX OR HEARTBURN?	___ OTHER? _____

HOSPITALIZATIONS (ILLNESS, INJURIES, SURGERIES, DATES)

IS THERE ANYTHING ELSE YOU THINK WE SHOULD KNOW?

I UNDERSTAND THE FOLLOWING (PLEASE INITIAL):

_____ THE HERNANDEZ CENTER OFFERS ADJUNCTIVE CANCER CARE DESIGNED TO INCREASE THE THERAPEUTIC EFFECTIVENESS OF MY CONVENTIONAL CANCER THERAPY. THE HERNANDEZ CENTER DOES NOT OFFER PRIMARY CANCER THERAPY.

_____ WHILE RECEIVING CARE AT THE HERNANDEZ CENTER, I WILL MAINTAIN A WORKING RELATIONSHIP WITH MY ONCOLOGIST.

_____ I UNDERSTAND THAT UPON REQUEST, THE HERNANDEZ CENTER/PACIFIC NATUROPATHIC WILL GIVE ME AN APPROPRIATELY CODED SUPERBILL TO SUBMIT TO MY INSURANCE COMPANY AND THAT SERVICES MAY OR MAY NOT BE REIMBURSED.

_____ I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED BY THE HERNANDEZ CENTER, WHETHER OR NOT I AM REIMBURSED LATER BY MY INSURANCE COMPANY. PAYMENT WILL BE MADE ON DAY OF SERVICE.

PRINT NAME _____

SIGN NAME _____ DATE _____

WITNESSED BY _____ DATE _____