CANCER MEDICAL HISTORY

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

Date of Birth: _____ Today's Date:_____

Who is your oncologist? _____

What type of cancer do you have? _____

_____

When were you first diagnosed? _____

What stage is your 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?

_____

_____

_____

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_____

_____

_____

_____

What side effects are you experiencing from your current treatment?

_____

_____

_____

_____

_____

What do you expect from treatment: Cure (achieving remission) or palliation (only improving quality of life)? _____

CANCER QUESTIONNAIRE

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

Date of Birth: _____ Today's Date:_____

SECTION 1: GENETICS AND EPIGENETICS			
1. Have you tested positive for BRCA1 and/or BRCA2?	☐ Yes	☐ No	☐ I don't know
2. Have you tested positive for any other type of gene mutation, including EPCAM, MLH1, MSH2, MSH6, PMS2, or TP53?	☐ Yes	☐ No	☐ I don't know
3. Are you heterozygous or homozygous for a MTHFR gene mutation?	☐ Yes	☐ No	☐ I don't know
4. Are you heterozygous or homozygous for a VDR, COMT, and/or CYP1B1 gene mutation?	☐ Yes	☐ No	☐ I don't know
5. Do you have a family history of cancer?	☐ Yes	☐ No	☐ I don't know
6. Were your grandparents affected by the Great Depression or any other type of famine, natural disaster, or major stressful period?	☐ Yes	☐ No	☐ I don't know
7. Were your parents exposed to large amount of stress and/or environmental toxins?	☐ Yes	☐ No	☐ I don't know
8. Did your mother smoke or take any types of drugs or medications while she was pregnant with you?	☐ Yes	☐ No	☐ I don't know
9. Did you experience any type of trauma in your childhood?	☐ Yes	☐ No	☐ I don't know
10. Do you take any pharmaceutical drugs, including over-the-counter medications?	☐ Yes	☐ No	☐ I don't know
SECTION 2: BLOOD SUGAR BALANCE			
1. Do you have a sweet tooth?	☐ Yes	☐ No	☐ I don't know
2. Do you find it difficult to fall asleep without an evening or late-night snack, and/or awaken hungry during the night?	☐ Yes	☐ No	☐ I don't know
3. Do you get "hangry" (irritable because of hunger) if meals are skipped or delayed?	☐ Yes	☐ No	☐ I don't know
4. Do you regularly skip breakfast?	☐ Yes	☐ No	☐ I don't know
5. Are sugar-based foods (e.g., candy, cookies. cake, soda, bread, waffles) what you crave the most, and/or consider your "comfort foods?"	☐ Yes	☐ No	☐ I don't know

6. Do you consume more than 25 grams of added sugar a day (more than one soda, candy bar, or flavored yogurt)?	☐ Yes	☐ No	☐ I don't know
7. Is your body-fat content over 25%?	☐ Yes	☐ No	☐ I don't know
8. Do you feel tired or crave sugar after a meal?	☐ Yes	☐ No	☐ I don't know
9. Do you or any family member have a history or diagnosis of metabolic syndrome, hypoglycemia, prediabetes, insulin resistance, polycystic ovarian syndrome (PCOS), pancreatitis, pancreatic cancer, or type 1 or 2 diabetes?	☐ Yes	☐ No	☐ I don't know
10. Do you consume alcoholic beverages more than 3 times per week?	☐ Yes	☐ No	☐ I don't know
SECTON 3: TOXIC BURDEN			
1. Do you currently live (or were you raised) near a toxic waste or factory site, military base, industrial complex, agricultural area, or airport?	☐ Yes	☐ No	☐ I don't know
2. Do you have any known environmental sensitivities, such as to odors like perfume or diesel fuel?	☐ Yes	☐ No	☐ I don't know
3. In total, do you use a microwave, cell phone, or laptop computer more than 3 hours a day?	☐ Yes	☐ No	☐ I don't know
4. Do you use pesticides or herbicides in or around your home or garden or on your pets?	☐ Yes	☐ No	☐ I don't know
5. Do you use any non-organic body care or household cleaning products (e.g., shampoo or laundry detergent) and/or have your hair professionally dyed?	☐ Yes	☐ No	☐ I don't know
6. Do you have your clothes dry-cleaned, use nonstick cookware, drink unfiltered water, or either drink from or store food in plastic containers?	☐ Yes	☐ No	☐ I don't know
7. Have you been exposed to first-hand, second-hand, or third-hand cigarette smoke?	☐ Yes	☐ No	☐ I don't know
8. Do you have any mercury fillings, work in a dental office, eat fish more than 3 times a week, and/or have you ever been exposed to heavy metals, including lead?	☐ Yes	☐ No	☐ I don't know
9. Do you have an occupational history with known exposure to toxic chemicals, such as asbestos or heavy metals?	☐ Yes	☐ No	☐ I don't know
10. Do you find it difficult to sweat?	☐ Yes	☐ No	☐ I don't know
SECTION 4: GUT MICROBIOME AND DIGESTIVE FUNCTION			
1. Were you born via cesarean delivery?	☐ Yes	☐ No	☐ I don't know

2. Were you fed infant formula before the age of one-year?	☐ Yes	☐ No	☐ I don't know
3. Have you ever, or do you now. use hand sanitizer and/or antimicrobial soap?	☐ Yes	☐ No	☐ I don't know
4. Have you been diagnosed with small intestine bacterial overgrowth (SIBO), ulcerative colitis, Crohn's disease, or colon cancer? Or do you have digestive symptoms such as gas, bloating, diarrhea, or constipation?	☐ Yes	☐ No	☐ I don't know
5. In your lifetime have you ever taken more than one course of antibiotics, or have you ever completed the recommended prep for a colonoscopy?	☐ Yes	☐ No	☐ I don't know
6. Do you eat non-organic meat and/or dairy products?	☐ Yes	☐ No	☐ I don't know
7. Have you had chemotherapy?	☐ Yes	☐ No	☐ I don't know
8. Do you take nonsteroidal anti-inflammatory drugs (NSAIDs), such as acetaminophen (Tylenol), aspirin, or ibuprofen (Motrin or Advil), or acid-blocking medications, such as Nexium, Prilosec, or Zantac more than a couple of times a year?	☐ Yes	☐ No	☐ I don't know
9. Do you typically eat fewer than 6 servings of different vegetables per day?	☐ Yes	☐ No	☐ I don't know
10. Do you eat processed non-organic grains such as pasta, bread, or cookies more than once a month?	☐ Yes	☐ No	☐ I don't know
SECTION 5: IMMUNE FUNCTION			
1. Have you been told that your vitamin D level is below 50 ng/mL?	☐ Yes	☐ No	☐ I don't know
2. Do you have a personal or family history of any autoimmune disease such as rheumatoid arthritis?	☐ Yes	☐ No	☐ I don't know
3. Do you use over-the-counter medications to suppress a fever?	☐ Yes	☐ No	☐ I don't know
4. Do you have a history of any of the following: Epstein-Barr virus (can cause infectious mononucleosis); human papillomavirus (HPV); cytomegalovirus (CMV); a sexually-transmitted disease (STD); herpes zoster (shingles); Lyme disease; yeast infection; or infection with a parasite?	☐ Yes	☐ No	☐ I don't know
5. Is either of the following true: You are never sick or you catch every cold and flu that comes your way?	☐ Yes	☐ No	☐ I don't know
6. Do you have allergies (i.e., seasonal allergies, asthma, hives, and/or allergies to certain foods)?	☐ Yes	☐ No	☐ I don't know

7. Have you been diagnosed with Celiac disease or gluten intolerance?	☐ Yes	☐ No	☐ I don't know
8. Have you ever received any vaccinations, including against seasonal influenza or herpes zoster, and vaccines needed for travel); or have you been prescribed any type of immunotherapies?	☐ Yes	☐ No	☐ I don't know
9. Have you ever taken steroids, such as cortisone or prednisone?	☐ Yes	☐ No	☐ I don't know
10. Do any children younger than 5 years live in your house and/or do you work in a school, hospital, or medical setting?	☐ Yes	☐ No	☐ I don't know
SECTION 6: INFLAMMATION			
1. Do you have a history of eczema, psoriasis, acne, flushing, or rashes?	☐ Yes	☐ No	☐ I don't know
2. Have you ever been diagnosed with arthritis. or do you suspect that you have it?	☐ Yes	☐ No	☐ I don't know
3. Do you have any physical pain patterns, including back or hip pain, that is either constant or intermittent?	☐ Yes	☐ No	☐ I don't know
4. Do you have Crohn's disease or ulcerative colitis?	☐ Yes	☐ No	☐ I don't know
5. Do you ever eat fried or fast foods?	☐ Yes	☐ No	☐ I don't know
6. Do you have any known food allergies or do you experience acid reflux?	☐ Yes	☐ No	☐ I don't know
7. Do you rely on NSAIDs for pain management?	☐ Yes	☐ No	☐ I don't know
8. Have you ever or do you now experience high amounts of stress?	☐ Yes	☐ No	☐ I don't know
9. Do you engage in vigorous exercise more than 5 days a week?	☐ Yes	☐ No	☐ I don't know
10. Are you overweight, do you consume alcohol, and/or do you eat fewer than 6 different vegetables a day?	☐ Yes	☐ No	☐ I don't know
SECTION 7: BLOOD CIRCULATION AND ANGIOGENESIS			
1. Do you bruise easily?	☐ Yes	☐ No	☐ I don't know
2. Have you ever been diagnosed with a clotting disorder?	☐ Yes	☐ No	☐ I don't know
3. Have you ever been diagnosed with hemochromatosis or elevated ferritin (iron) level?	☐ Yes	☐ No	☐ I don't know
4. Do you have a history of deep vein thrombosis (DVT)?	☐ Yes	☐ No	☐ I don't know
5. Do you have a history of pulmonary embolism (PE)?	☐ Yes	☐ No	☐ I don't know

6. Do you have high or low blood pressure?	☐ Yes	☐ No	☐ I don't know
7. Do you drink less than 2 quarts of water a day?	☐ Yes	☐ No	☐ I don't know
8. Do you take any pharmaceutical anticoagulants, such as warfarin (Coumadin) or enoxaparin (Lovenox)?	☐ Yes	☐ No	☐ I don't know
9. Are you on medication to control your blood pressure and/or do you take a daily aspirin?	☐ Yes	☐ No	☐ I don't know
10. Do you exercise less than 30 minutes 3 times a week?	☐ Yes	☐ No	☐ I don't know
SECTION 8: HORMONE BALANCE			
1. Do you have a history of birth control pills, bioidentical or standard hormone replacement therapy. steroid use, fertility treatments, and/or hormone-blockade therapies?	☐ Yes	☐ No	☐ I don't know
2. Women: Do you have a history of premenstrual syndrome (PMS), irregular cycles, fibrous breasts, and/or menopausal symptoms?	☐ Yes	☐ No	☐ I don't know
3. Women: Do you have a history of fertility problems, including miscarriage?	☐ Yes	☐ No	☐ I don't know
4. Men: Do you have difficulty getting or maintaining an erection?	☐ Yes	☐ No	☐ I don't know
5. Do you have a low libido (sex drive)?	☐ Yes	☐ No	☐ I don't know
6. Have you ever been diagnosed with a thyroid disorder?	☐ Yes	☐ No	☐ I don't know
7. Have you ever been diagnosed with adrenal fatigue and/or low cortisol levels?	☐ Yes	☐ No	☐ I don't know
8. Do you experience weight fluctuations of more than 10 pounds on a regular basis?	☐ Yes	☐ No	☐ I don't know
9. Do you handle store receipts, drink out of plastic bottles, have exposure to paraben-containing products, or eat non-organic animal protein more than once a month?	☐ Yes	☐ No	☐ I don't know
10. Do you now or have you ever followed a low-fat diet?	☐ Yes	☐ No	☐ I don't know
SECTION 9: STRESS AND BIORHYTHMS			
1. Did any of your symptoms or lab results worsen after a stressful period? And/or, if you have a cancer diagnosis. was the diagnosis made following a stressful period?	☐ Yes	☐ No	☐ I don't know
2. Are you a night owl and/or have you ever had a job working at night or caring for a small child who kept you up late?	☐ Yes	☐ No	☐ I don't know
3. Do you often travel back and forth across many time zones?	☐ Yes	☐ No	☐ I don't know

4. Are there lights on while you sleep during the night (e.g., streetlights or a TV)?	☐ Yes	☐ No	☐ I don't know
5. Do you feel you are you easily fatigued?	☐ Yes	☐ No	☐ I don't know
6. Do you often crave salt?	☐ Yes	☐ No	☐ I don't know
7. Do you sleep fewer than 8 hours a night and/or go to bed after 11:00 pm?	☐ Yes	☐ No	☐ I don't know
8. Do you have screen time (i.e., watch TV or use an electronic device) after 5:00 pm?	☐ Yes	☐ No	☐ I don't know
9. Do you spend less than 15 minutes outdoors every day?	☐ Yes	☐ No	☐ I don't know
10. Do you feel that you experience high levels of stress every day?	☐ Yes	☐ No	☐ I don't know
SECTION 10: MENTAL AND EMOTIONAL HEALTH			
1. Do you experience irritability, mood swings, and/or unstable emotions?	☐ Yes	☐ No	☐ I don't know
2. Have you been diagnosed with a mental disorder (e.g., bipolar disorder, depression, anxiety)?	☐ Yes	☐ No	☐ I don't know
3. Are you easily offended?	☐ Yes	☐ No	☐ I don't know
4. Are you sensitive to other people's energy and reactions?	☐ Yes	☐ No	☐ I don't know
5. Do you ever experience racing, repetitive thoughts?	☐ Yes	☐ No	☐ I don't know
6. Do you find it difficult to speak the truth in certain situations?	☐ Yes	☐ No	☐ I don't know
7. Have you ever used drugs or alcohol, sex, shopping, TV, gambling, gaming, or time on the internet to self-medicate?	☐ Yes	☐ No	☐ I don't know
8. Do you feel that you lack a good support system, such as a supportive spouse, friends, and/or spiritual community?	☐ Yes	☐ No	☐ I don't know
9. Do you feel like your life lacks purpose or direction?	☐ Yes	☐ No	☐ I don't know
10. Do you find it difficult to feel gratitude and joy?	☐ Yes	☐ No	☐ I don't know