Medical History Related to Diagnosis

Gerson Institute

Please fill out the items below with as much information as you can provide. After you have finished, please save this form and attach it in an email to the practitioner or print it out and fax it to the provided number. Thank you!

Name: E-mail: Telephone:

Street address: City: State: Zip code: Country:

Occupation: Date of birth: Gender:

Male

Female

Please fill out the following information about your diagnosis.

Diagnosis: Date of initial diagnosis:

For cancer diagnosis.

Type of cancer: Primary site:

Stage: Grade (if known): Describe location of metastasis, if any:

If you have a breast cancer diagnosis, please fill out the following information.

Receptor status:

ER+ ER- PR+

PR- HER2/neu+ HER2/neu-

Genetic marker:

BRAC I BRAC II

Type:

Intraductal Intraductal (DCIS) Introlobular Introlobular (LCIS)

Inflammatory

Other

Were any of the following used in diagnosis? (Attach copy of written interpretations)

MRI CAT scan Ultrasound PET scan X-Rays

Other

Please check any past or current treatment used for your diagnosis and fill out the additional information.

Surgery # of times: Date: Description:

Yes No

Chemotherapy # of times: Date: Description:

Yes No

Radiation # of times: Date: Description:

Yes No

Hormone Therapy # of times: Date: Description:

Yes No

Other, please explain:

Was there a recurrence after treatment?

Yes No

If so, please describe:

Describe treatment, if any for recurrence:

Please describe current status:

Please make a selection that describes your health status based on the Karnofsky Performance Scale.

Description:

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

Other health concerns. Please list in order of significance and describe treatment.

1. Treatment taken/date:

2. Treatment taken/date:

3. Treatment taken/date:

4. Treatment taken/date:

5. Treatment taken/date:

Health History:

Height: Weight: Weight one year ago: Maximum weight: When?

Health as a child was:

Good Fair Poor

Childhood Illnesses:

Scarlet fever	German measles	Measles	Pertussis
Mumps	Rheumatic fever	Chicken pox	Diptheria

Other Illnesses (past or present):

Tuberculosis	Asthma	Osteoarthritis	Rheumatoid arthritis
Pneumonia	Typhoid	Tonsilitis	Gonorrhea
Hypertension	Herpes	Epilepsy	Diabetes
Hay fever	Alcoholism	Heart disease	Hepatitis
Mononucleosis	Kidney disease	Stroke	Glaucoma
SLE (Lupus)	Thyroid disorder	Infertility	Lyme disease
Depression			
Others			

Hospitalizations (year and reason):

Surgeries (year and type):

Significant falls or injuries:

Serious illnesses (year and cause):

Vaccinations (year,type, adverse reactions):

Date of last medical exam: [ ] Where?

Date of last blood test: [ ] Where?

Other recent tests: Where and when?

Family history. Please only indicate 'age' if family member is living.

Mother Age: State of health:

Father Age: State of health:

Siblings Age: State of health:

Children Age: State of health:

Please check family history conditions.

Cancer	Diabetes	Heart disease
High blood pressure	Stroke	Epilepsy
Asthma	Mental illness	Hay fever
Alcoholism	Glaucoma	Hives
Kidney disease	Physical or emotional abuse	Tuberculosis
Others		

Medications. Please include dosage and how long taken.

Prescription Medications:

Non-prescription: Herbs and vitamins

Allergies

List any allergies or adverse reactions to inhalants, foods, medicines, perfumes, smoke, chemicals, etc.

Have you had an occupational or environmental exposure to noxious or hazardous substances?

Yes No

If yes, please explain:

Have you ever been exposed to any of the following?

Agricultural chemicals (pesticides, insecticides)?	Yes No	How long?	How much?
Industrial/workplace chemicals?	Yes No	How long?	How much?
Cigarette smoking?	Yes No	How long?	How much?
Second hand smoke?	Yes No	How long?	How much?
Alcohol use?	Yes No	How long?	How much?
Recreational drugs?	Yes No	How long?	How much?

Electromagnetic fields? Yes No How long? How much?

Other? Yes No Explain:

Habits:

Do you drink coffee? Which kind: How many cups per day?

- Yes, currently
- Yes, in the past
- No

Caffeinated Decaffeinated

Do you drink alcoholic beverages? What kind? How many per week?

- Yes, currently
- Yes, in past
- No

Tobacco: Do you smoke/chew? How many years? How much? How often?

- Yes, currently
- Yes, in past
- No

Recreational drug use? Explain:

- Yes, currently
- Yes, in past
- No

General:

Do you sleep well? Yes No

Average hours per night:

Do you wake rested? Yes No

Do you exercise regularly? What type? How often?

- Yes
- No

How would you describe your sense of well-being?

What is your stamina or general energy like?

Food issues/sensitivities:

Do you have any food allergies?

- Yes
- No

If yes, please list:

Do any foods give you significant gas, pain, or bloating?

If yes, please list:

Yes

No

Gastrointestinal:

Does food generally sit well in your stomach and digest without difficulty?

Yes No

Are your bowel movements generally formed or loose?

Color?

How often do you have a bowel movement?

Do you have gas or abdominal bloating?

Yes No

Do you need to strain to have a bowel movement?

Yes No

Do you have hemorrhoids or any other rectal or bowel problems?

Yes No

If yes, please explain:

Diet: *Please include TWO samples of each meal (what you eat everyday or nearly everyday). Include what you drink with your meals, desserts, and snacks.*

Breakfast 1:

Breakfast 2:

Morning snack 1:

Morning snack 2:

Lunch 1:

Lunch 2:

Afternoon snack 1:

Afternoon snack 2:

Dinner 1:

Dinner 2:

General digestion problems - past & present:

Acid indigestion:

- No
- Yes, past
- Yes, currently

Acid reflux:

- No
- Yes, past
- Yes, currently

Colitis:

- No
- Yes, past
- Yes, currently

Constipation:

- No
- Yes, past
- Yes, currently

Diarrhea:

- No
- Yes, past
- Yes, currently

Diverticulitis:

- No
- Yes, past
- Yes, currently

Hiatal hernia:

- No
- Yes, past
- Yes, currently

Irritable Bowel Syndrome:
- No
- Yes, past
- Yes, currently

Ulcers:
- No
- Yes, past
- Yes, currently

Female Gynecological History:

Age menses began:

Number of flow days:

Cycle length:

Date of last menstrual period:

Excessive cramping: Yes No

Excessive flow: Yes No

Bleeding or spotting between periods: Yes No

Abnormal discharge: Yes No

Regular cycles? Yes No

Experience symptoms or premenstrual tension: Yes No

Do you have a history of any of the following vaginal infections?

Yeast Gonorrhea Syphilis Herpes Chlamydia
Vaginitis HPV (wart virus)

Do you have a history of ovarian cysts, uterine fibroids or endometriosis? If so, please explain:

Date of last pap:

Pap status:
- Normal
- Abnormal

If you have had an abnormal pap, when?

Please list the number of each of the following:

Pregnancies: Live births: Miscarriages: Abortions:

Type of birth control:

Difficulty conceiving? Yes No

Pain on intercourse? Yes No

Menopausal symptoms:

Sexually active? Yes No

Having sexual difficulties? Yes No

Breasts:

I do self exams regularly:
- Yes
- No

Consistently have lumps:
- Yes
- No

Nipple discharge:
- Yes
- No

Implants:
- Yes
- No

Any pain or tenderness?
- Yes
- No

Have you had a mammogram?
- Yes
- No

If yes, when?

Results:
- Normal
- Abnormal

Comments:

Review of Systems -
Please check appropriate response:
Y = condition you 'currently' have **N** = condition you 'never' had **P** = condition you had in the 'past'

Night sweats: Y P N
Fatigue: Y P N

Skin:

Rashes: Y P N
Inflammation: Y P N
Infection: Y P N
Change in hair/nails: Y P N
Growths: Y P N

Head:

Headache: Y P N
Head injury: Y P N
Dizziness: Y P N

Eyes and Ears:

Impaired vision: Y P N
Ringing: Y P N
Ache/itch: Y P N

Nose and Sinus:

Post nasal drip: Y P N
Frequent colds: Y P N
Nose bleeds: Y P N
Stuffiness: Y P N
Sinus problems: Y P N

Neck:

Swollen glands: Y P N
Pain/stiffness: Y P N

Mouth & Throat:

Sore tongue: Y P N
Gum problems: Y P N
Dental problems: Y P N

Frequent sore throat: Y P N

Sores in mouth or on lips: Y P N

Hoarseness: Y P N

Root canals: Y P N

Amalgam fillings: Y P N

If amalgam fillings were removed, when:

Blood:

Anemia: Y P N

Easy bleeding/bruising: Y P N

Respiratory:

Cough: Y P N

Wheezing: Y P N

Spitting blood: Y P N

Pain on breathing: Y P N

Positive TB test: Y P N

Difficulty breathing: Y P N

Shortness of breath: Y P N

When?
lying down at night
Other

Heart:

Heart disease: Y P N

High blood pressure: Y P N

Rheumatic fever: Y P N

Chest pain: Y P N

Palpitations: Y P N

Ankle swelling: Y P N

Digestion:

Heartburn: Y P N

Nausea: Y P N

Vomiting: Y P N

Hemorrhoids: Y P N

Loose stools: Y P N

Belching or gas: Y P N

Stomach pain: Y P N

Blood in stools: Y P N

Trouble swallowing: Y P N

Liver/gallbladder disease: Y P N

Urinary:

Pain on urination: Y P N

Frequency at night: Y P N

Increased frequency: Y P N

Inability to hold urine: Y P N

Vomiting: Y P N

Bladder infections: Y P N

Neurological:

Fainting: Y P N

Seizures: Y P N

Paralysis: Y P N

Muscle weakness: Y P N

Numbness or tingle: Y P N

Loss of memory: Y P N

Emotional:

Anxiety or nervousness: Y P N

Mood swings: Y P N

Depression: Y P N

Tension: Y P N

Musculoskeletal:

Joint pain or stiffness: Y P N

Broken bones: Y P N

Weakness: Y P N

Muscles spasms/cramps: Y P N

Endocrine:

Thyroid problems: Y P N

Excessive thirst: Y P N

Excessive hunger: Y P N

Heat or cold intolerance: Y P N

Excessive weight gain: Y P N

Circulation:

Deep leg pain: Y P N

Cold hands or feet: Y P N

Varicose veins: Y P N

Male Reproductive System:

Hernias: Y P N

Testicular masses: Y P N

Venereal diseases: Y P N

Prostate problems: Y P N

Discharge or sores: Y P N

Sexual difficulties: Y P N

Sexually active:

Y P N

Difficulty starting or stopping urine:

Y P N

Additional comments: