Oncological Medical Record Sheet

(in the case of cancer, please send or fax this sheet prior and **in addition** to the general medical record sheet 089-54329907)

Family name:................................... **First name**:..............................
Date of Birth: ....

Street:...................................... **ZIP / Postal code**..............................
City:................................

Phone private: .... **Phone work**:..................
Fax private: ....

Mobile phone:...................................

Email:..

Insurance company: ....

Cancer type: ___________________________________

Cancer diagnosis on (please add date):

____

Which indicators / symptoms (circulatory collapse, knots, etc.) are connected to your tumor?

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Present laboratory diagnostics:

Which tumor markers have been determined in the laboratory:

CEA:

No ☐ Yes ☐ Date:_ _ _ _ _ _ _ _ _ _ _ _ Value:_ _ _ _ _ _ _ _ _ _ _ _

CA 15-5:

No ☐ Yes ☐ Date:_ _ _ _ _ _ _ _ _ _ _ _ Value:_ _ _ _ _ _ _ _ _ _ _ _

PSA:

No ☐ Yes ☐ Date:_ _ _ _ _ _ _ _ _ _ _ _ Value:_ _ _ _ _ _ _ _ _ _ _ _

Other tumor markers:

No ☐ Yes ☐ Date:_ _ _ _ _ _ _ _ _ _ _ _ Value:_ _ _ _ _ _ _ _ _ _ _ _

Has the TKTL-1 Test been tested?

No ☐ Yes ☐ Date:_ _ _ _ _ _ _ _ _ _ _ _ Value:_ _ _ _ _ _ _ _ _ _ _ _

Has Selen been tested?

No ☐ Yes ☐ Date:_ _ _ _ _ _ _ _ _ _ _ _ Value:_ _ _ _ _ _ _ _ _ _ _ _

Has vitamin D been tested?:

No ☐ Yes ☐ Date: :_ _ _ _ _ _ _ _ _ _ _ _ Value: :_ _ _ _ _ _ _ _ _ _ _

Have hormones been tested?

No ☐ Yes ☐ Date: :_ _ _ _ _ _ _ _ _ _ _ _ Value: :_ _ _ _ _ _ _ _ _ _ _

Have estrogen metabolites been tested?

No ☐ Yes ☐ Date: :_ _ _ _ _ _ _ _ _ _ _ _ Value: :_ _ _ _ _ _ _ _ _ _ _

Has your lactate level been measured?

No ☐ Yes ☐ Date: :_ _ _ _ _ _ _ _ _ _ _ _ Value: :_ _ _ _ _ _ _ _ _ _ _

I have a kidney condition:

No ☐ Yes ☐ which? :_ _ _ _ _ _ _ _ _ _ _ _

I have a liver condition:

No ☐ Yes ☐ which? :_ _ _ _ _ _ _ _ _ _ _ _

I have a heart condition:

No ☐ Yes ☐ I use a pace-maker: No ☐ Yes ☐

<u>Oncological therapy until now:</u>

(please add - as far as is known – chemo-therapy, operations, radiation treatment, medication as well as nutrition supplements)

_ treatment period from _ _ _ _ _ till _ _ _ _ _

_ treatment period from _ _ _ _ _ till _ _ _ _ _

_ treatment period from _ _ _ _ _ till _ _ _ _ _

_ treatment period from _ _ _ _ _ till _ _ _ _ _

_ treatment period from _ _ _ _ _ till _ _ _ _ _

<u>Actual medication:</u> (please add your medications including homeopathic globules - in case you have not done so already on the general medical record sheet)

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Which image material, such as x-ray, CT and magnetic resonance imaging, have been produced until now?

Your treating oncologist:

Name: _

Address: _

Telephone: _

Do you want us to contact and coordinate with your treating oncologist? Yes ☐ No ☐

Cancer history in your family:

What is your personal therapy goal? :