Wildwood

Oncology Intake Form

Date:_____/_____/_____

PATIENT INFORMATION

Name:

Date of Birth (mm/dd/yyyy): / / Gender:

Address:

City: Zip:

Phone (primary): (secondary): Employer:

E-mail:

Emergency contact: Phone: Relationship:

Medical doctor: MD Tel:

Names of other healthcare providers:

How did you hear about Wildwood:

Optimal health is only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. Your time, thoughtfulness and honesty in completing this confidential overview will greatly assist our understanding of your healthcare needs and desires.

Current Health Concerns; Please list health concerns and goals in their order of importance:

Oncology History

Initial Diagnosis/Tumor Type, with date:

Date of Subsequent Diagnoses/Metastases, if applicable:

What has your oncologist advised re: current prognosis?

Please describe your family history of cancer:

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Cancer Treatment To Date

Surgery, Date:

Radiation, Date:

Chemotherapy, Date:

Other Therapies, Date:

Current health issues related to previous oncology treatment:

Treatments received for these side effects, please note if helpful:

What do you think contributed to the development of the cancer?

Care Goals and Approach

Why did you choose Dr. Renee Lang for your integrative oncology care?

What three expectations do you have from this consult?

What are your long-term expectations, goals?

What is your present level of commitment to address any underlying causes of illness that relate to lifestyle? (0-100%)

What do you regularly do to support achieving optimal health? (Please list)

What do you regularly do that interferes with achieving optimal health? (Please list)

What potential obstacles do you foresee in addressing the lifestyle factors undermining your health and/or in adhering to the therapeutic protocols recommended to you?

Who in your life will sincerely and consistently support the lifestyle changes you'll be making?

What do you love to do?

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Therapeutic Options

Please list the natural therapies you're most interested in receiving or that work well for you:

_____

_____

_____

If necessary to reach my health goals, I am able and willing to:

- ○ Eat new foods
- ○ Take pills
- ○ Take large pills (e.g. fish oil)
- ○ Drink herbal tea
- ○ Drink a smoothie
- ○ Exercise
- ○ Take herbal extracts
- ○ Change my daily lifestyle habits
- ○ Do spa-like care therapies that take 20-30 min daily

Any special needs re: therapeutic options? (e.g. no alcohol, difficulty swallowing, sensitivity to medications)

Personal and Family Medical History

Surgery, Serious Injury, or Accidents
Please list surgical procedures (Excluding those listed in Oncology History):

Type	Year

Childhood illnesses: Your health as a child was: □Good □Fair □Poor
Indicate if you had any of the following childhood illnesses (check all that apply):

- ☐Scarlet Fever
- ☐German Measles
- ☐Measles
- ☐Pertussis
- ☐Strep
- ☐Mono
- ☐Polio
- ☐Chronic Ear Infections
- ☐Diptheria
- ☐Mumps
- ☐Chicken Pox
- ☐Rheumatic Fever
- ☐Pneumonia
- ☐Other:

Immunizations (check all that apply):

- ☐MMR
- ☐DTaP
- ☐Hep B
- ☐Rota
- ☐Hib
- ☐Polio
- ☐Pneumococcal
- ☐Varicella
- ☐Hep A
- ☐Meningococcal
- ☐HPV
- ☐Other:

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Please indicate most recent: Tetanus_____ Flu Shot_____

Have you had a TB test in the last year? □YES □NO

Have you ever tested positive for TB? □YES □NO

Note “C” for current or “P” for past in the box next to each condition as it applies to you or your family.

	Self	**Mother**	**Father**	**Sisters**	**Brothers**	**Spouse**	**Maternal Relatives**	**Paternal Relatives**
Age (if living)								
Age (at death)								
Cause of death								
Health; **G** = good, **P** = poor								
Alcoholism								
Allergies/ Hay fever/ Asthma								
Anemia								
Autoimmune Disease								
Bleeding Disorder								
Chronic Fatigue								
Diabetes								
Epilepsy/ Seizures								
Glaucoma								
Genetic Disease								
Heart Disease								
Hepatitis								
Herpes								
High Blood Pressure								
High Cholesterol								
Kidney or Bladder Trouble								
Mental or Nervous Disorder								
Osteoporosis								
Rheumatism/ Arthritis								
Stomach/ Ulcer								
Stroke								
Thyroid Disorder								
Tuberculosis								
Venereal Disease								
Other (specify)								

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ALLERGIES

Medications:_____

Foods: _____

Environmental: _____

Sensitivities: □Perfumes □Cigarette smoke □Cleaning supplies

Social History and Health Habits

Height_____Weight_____Optimal weight_____

Do you use:	Currently/Past	Quit Date (if applicable)	What and How Much (if applicable)
Caffeinated Beverages			
Tobacco			
Alcohol			
Recreational Drugs			

Do you exercise regularly? □YES □NO If no, why?_____

What exercise? _____

Do you sleep soundly and wake rested? □YES □NO How many hours do you get per night: _____

If no, please describe?

Please rate your stress level out of 10 on average (10 worst stress): _____ Is this a change? □YES □NO

Do you manage stress well? □YES □NO □NOT SURE

Are you sexually active? □YES □NO Contraception? _____

Are you satisfied with your sex life? □YES □NO If no, why? _____

Are you satisfied with your social life? □YES □NO If no, why? _____

Are you satisfied with your spiritual life? □YES □NO If no, why? _____

Do you consider your diet healthy? □YES □NO □NOT SURE

Dietary restriction or regimen? _____

What diets have you been on? □Atkins □South Beach □Blood Type □Weight Watchers Other:_____

How much water do you drink per day? _____

What are your symptoms if you miss a meal? □Headache □Irritable □Light-headed □Shaky □Tired

Do you have a history of significant/notable toxic exposure? □YES □NO

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Diet Recall

	Food on a “good” weekday	Food on a “bad” weekday	Typical Weekend
Breakfast Time:			
Lunch Time:			
Dinner Time:			
Snacks Time:			

Current Medications: Prescription or Over the Counter

Medication	Dose	Frequency	Purpose	Prescribing Physician	Start Date (mo/yr)

Past history of long-term antibiotic use? □YES □NO How long? _____

Past history of long-term corticosteroid use? □YES □NO How long? _____

Current Supplements

Name	Brand	Dose	Frequency	Reason	Prescriber	Start Date (mo/yr)

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CURRENT SYMPTOMS

✓	General	✓	Digestion	✓	Nerves and Brain
	Fatigue		Nausea		Dizziness
	Fever		Vomiting		Headache
	Chills		Diarrhea		Tremors
	Night Sweats		Constipation		Memory Problems
	Poor Appetite		Gas/bloating after meals		Seizures
	Weight Change		Gas/bloating throughout the day		Peripheral Neuropathy
✓	**Eyes, Ears, Nose, Throat**		Indigestion/Heartburn		Muscle Weakness
	Hair Loss		Abdominal Pain		Tremors
	Vision Changes		Blood/mucous in stool	✓	**Hematologic/Lymphatic**
	Eye Pain		Hemorrhoids		Easy bleeding or bruising
	Hearing Changes	✓	**Genitourinary**		Anemia
	Ear Pain		Urination painful/difficult		Swelling
	Ringing in ears		Night urination > 2x/night	✓	**Endocrine & Skin**
	Changes in taste/smell		Blood in urine		Hot/cold intolerance
	Nasal discharge		Incontinence		Altered thirst or hunger
	Nose bleeds		Urinary urgency/frequency		Rash, Eczema, Itching
	Throat pain/ sore throat		Sexual dysfunction		Hair, skin, nail changes
	Swallowing difficulty		Low libido/ Orgasm difficulty	✓	**Allergy/Immunology**
✓	**Respiratory**		Abnormal uterine bleeding		Autoimmune disease
	Cough		Painful/heavy menses		Immune deficiency
	Shortness of breath	✓	**Cardiovascular**	✓	**Psychiatric**
	Asthma		Chest pain		Anxious mood
✓	**Musculoskeletal**		Palpitations		Depressed mood
	Muscle pain:		Unusual ankle swelling		Irritability/mood changes
	Joint/Bone pain:		Varicose veins		Sleep disturbance/ insomnia

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Laboratory and Exam History

Exam	Date (mo/yr)	Normal	Abnormal, describe:
Full Physical Exam			
Blood work			
Cholesterol			
Blood glucose			
Hemoglobin A1C			
TSH or Thyroid Panel			
Vitamin D3			
Urinalysis			
Hemoccult/ blood in stool			
Colonoscopy			
DEXA/ bone scan			
Eye Exam			
Dental Exam			
Chest X-RAY			
PET, CT, or MRI			
Women Only			
Breast Exam			
Pelvic Exam			
Mammogram			
Men Only			
Prostate Exam			
PSA			

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

Printed Name: _____ Date _____

Signature: _____ Relationship to Patient: _____

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Release of Medical Information/ Coordination of Care

Patient name: _____ Date of Birth: _____ Phone: _____

Please provide contact information for healthcare providers with whom you'd like Dr. Renee Lang to coordinate your care.

I hereby grant permission to the authorized employees or agents of (**released from**):

Primary Care Physician
Physician Name: _____ Nurse Name: _____
Phone: _____ Fax: _____
Clinic Address: _____
May we contact to coordinate care: □YES □NO Should we request records? □YES □NO

Medical Oncologist
Physician Name: _____ Nurse Name: _____
Clinic Name: _____ Website: _____
Phone: _____ Fax: _____
Clinic Address: _____
May we contact to coordinate care: □YES □NO Should we request records? □YES □NO

Naturopathic Doctor
Physician Name: _____ Nurse Name: _____
Clinic Name: _____ Website: _____
Phone: _____ Fax: _____
Clinic Address: _____
May we contact to coordinate care: □YES □NO Should we request records? □YES □NO

Other
Physician/Practitioner Name: _____ Nurse Name:_____
Clinic Name: _____ Website: _____
Phone: _____ Fax: _____
Clinic Address: _____
May we contact to coordinate care: □YES □NO Should we request records? □YES □NO

Information may be RELEASED TO (**receiver**):

Wildwood
83 India Street, Portland, ME 04101
Phone: 207.347.7132 Fax: 207.347.3527

I understand that this consent is subject to revocation, in writing, at any time unless action based on this release has already been taken. I understand that further disclosure of the information to be disclosed may not be made without my written consent.

_____ _____ _____
Patient Signature Effective Date Expiration Date (If any)

_____
Parent or GuardianRelationship to Patient