Name:        Sex:

Telephone:       Email:

Height:     cm Weight:     kg Born (dd/mm/yyyy):   .   .

Have you been diagnosed a tumor or cancer?

no yes,

microscopy diagnosis (PAD):       (e.g. carcinoma ductale mammae), (date)   .   .

Operated

no  yes, operation: which, (date)   .   .

Metastasis

no  yes, location: where

Radiotherapy

no  yes, started (date)   .   .     , given    times, altogether:    Gy

Chemotherapy

no  yes, started (date)   .   .     , given    times

Hormone treatment

no  yes, started (date)   .   .     , medication:

Medical records are obtainable and will be sent

no  yes

Pathology microscopy glassed obtainable and will be sent

no  yes

X-ray, MRI or other images obtainable and will be sent

no  yes

What other disease(s) have you had or are having, and how are it/those treated?

|  |  |  |  |
| --- | --- | --- | --- |
| Disease | Started | Ongoing/ended | Treatment |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Ongoing medication

|  |  |  |  |
| --- | --- | --- | --- |
| Drug (name) | Concetration | Dose | Started (about) |
|  |  | /day |  |
|  |  | /day |  |
|  |  | /day |  |

Which painkiller medication did you use yesterday, if any?

|  |  |  |  |
| --- | --- | --- | --- |
| Drug (name) | Concetration | Dose | Started (about) |
|  |  | /day |  |
|  |  | /day |  |

General condition (answer all 1-10; 1=very bad, 10=very good)

* how do you feel today:
* how is short walking outside home going:
* pain on sitting/laying down:
* pain on walking/movement:

How old were you when started menstruation:    How old were you when ended menstruation:

Hormone treatment (for post-menopausal purposes)

none for    years

Something else you want to mention: