



Select the appropriate option and/or provide an answer to each of the items below:

OVERVIEW OF HISTORY

Patient's Name & Current Date	
Patient is from (city, state, country)	
Patient's Age & DOB	_____ Age _____ Birthdate
Patient Marital Status	<input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Partner
Patient's Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex / Hermaphrodite <input type="checkbox"/> Transgender
Patient's Ethnicity	<input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Other (please specify)
How did you hear about our clinic?	
What is your current Primary Diagnoses?	

HISTORY OF PRESENT ILLNESS

Date symptoms began (onset of actual symptoms)	
WHAT was the first evidence of the problem?	
WHEN was first evidence of the problem beginning?	
Date diagnosed	
How was diagnosis made?	<input type="checkbox"/> EKG (Electrocardiogram) <input type="checkbox"/> Stress Test <input type="checkbox"/> Echocardiography <input type="checkbox"/> Cardiac Catheterization <input type="checkbox"/> Chest X Ray <input type="checkbox"/> Blood Tests <input type="checkbox"/> Coronary Angiography <input type="checkbox"/> Other (please specify)
Who made the diagnosis?	

INITIAL SYMPTOMS BEFORE DIAGNOSIS

Constitutional symptoms prior to diagnosis	<input type="checkbox"/> Weight change <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Appetite change <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Night sweats <input type="checkbox"/> Pain <input type="checkbox"/> Fatigue <input type="checkbox"/> Exhaustion <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Chest pain <input type="checkbox"/> Weakness <input type="checkbox"/> Have to sit up to breath (orthopnea) <input type="checkbox"/> Pain when breathing (dyspnea) <input type="checkbox"/> Radiating pain in jaw or arms <input type="checkbox"/> Other (please specify)
Weight when initial symptoms began	_____ lbs <input type="checkbox"/> Eating Healthy <input type="checkbox"/> Exercising <input type="checkbox"/> Dieting
Appetite when initial symptoms began	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> No Appetite

SYMPTOMS AT TIME OF DIAGNOSIS

Constitutional symptoms at time of diagnosis	<input type="checkbox"/> Weight change <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Appetite change <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Night sweats <input type="checkbox"/> Pain <input type="checkbox"/> Fatigue <input type="checkbox"/> Exhaustion <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Chest pain <input type="checkbox"/> Weakness <input type="checkbox"/> Have to sit up to breath (orthopnea) <input type="checkbox"/> Pain when breathing (dyspnea) <input type="checkbox"/> Radiating pain in jaw or arms <input type="checkbox"/> Other (please specify)
Weight at time of diagnosis (lbs)	_____ lbs <input type="checkbox"/> Eating Healthier <input type="checkbox"/> Increased Exercise <input type="checkbox"/> Continued Dieting
Appetite at time of diagnosis	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> No Appetite

CURRENT SYMPTOMS AS OF TODAY

Cardiac Intake Form

Select the appropriate option and/or provide an answer to each of the items below:

Constitutional symptoms as of today	<input type="checkbox"/> Weight change <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Appetite change <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Night sweats <input type="checkbox"/> Pain <input type="checkbox"/> Fatigue <input type="checkbox"/> Exhaustion <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Chest pain <input type="checkbox"/> Weakness <input type="checkbox"/> Have to sit up to breath (orthopnea) <input type="checkbox"/> Pain when breathing (dyspnea) <input type="checkbox"/> Radiating pain in jaw or arms <input type="checkbox"/> Other (please specify)
Current weight (lbs)	_____ lbs <input type="checkbox"/> Eating Healthier <input type="checkbox"/> Increased Exercise <input type="checkbox"/> Continued Dieting
Current appetite	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> No Appetite
HISTORY OF TREATMENTS RELATED TO DIAGNOSIS	
Surgeries history related to diagnosis (dates and type)	
Condition after treatment regimen or surgery	
CURRENT SITUATION	
Primary problem today?	
When did primary problem start?	
Where is primary problem located?	
When is problem worse, and for how long?	
How often does problem occur?	
When is the problem better?	
What has been done to help problem?	
What treatments have been successful in helping the problem?	
Experiencing any pain? Where?	
Complications since diagnosis	
Medications currently being taken and purpose	

Cardiac Intake Form

Select the appropriate option and/or provide an answer to each of the items below:

Any other information regarding your diagnosis you feel is pertinent for the provider to know?	
EXPOSURE HISTORY	
History and recent use of Tobacco (how much, how long, dates used)	
History and recent use of Alcohol (type used, how much, how long, dates used)	
History and recent use of Illicit Drug (type used, how much, how long, dates used)	
Chemical Exposure History (type, how much, how long, dates) Examples: Pesticides, Fuel, Fertilizers, Insecticides	
Metals Exposure History (type, how much, how long, dates) Examples: Lead, Aluminum, Mercury, Copper, Steel	
Any amalgams (mercury fillings) removed?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many? _____
How many amalgams does patient currently have?	
Does patient have a high seafood diet?	
What vaccines has the patient had? (Give general information)	
How many antibiotics has patient taken in the past year?	
Context (check all that apply)	<input type="checkbox"/> pain at rest <input type="checkbox"/> pain during physical exertion <input type="checkbox"/> increased belching/burping <input type="checkbox"/> pain while walking after eating <input type="checkbox"/> postural change <input type="checkbox"/> pain after eating
Associated Symptoms (check all that apply)	<input type="checkbox"/> numbness <input type="checkbox"/> palpitations <input type="checkbox"/> orthopnea <input type="checkbox"/> tingling <input type="checkbox"/> dyspnea <input type="checkbox"/> diaphoresis <input type="checkbox"/> heartburn <input type="checkbox"/> belching <input type="checkbox"/> sexual dysfunction <input type="checkbox"/> sweating
Cardiac Risk Factors (check all that apply)	<input type="checkbox"/> thickened toenails <input type="checkbox"/> less hair on toes or fingers <input type="checkbox"/> thickened skin on feet <input type="checkbox"/> cold hands & feet <input type="checkbox"/> purple color to toes or feet
Quality of symptoms (check all that apply)	<input type="checkbox"/> acute <input type="checkbox"/> constant <input type="checkbox"/> crushing <input type="checkbox"/> dull <input type="checkbox"/> pressure <input type="checkbox"/> tightness
MEDICAL HISTORY	
Do you have any other medical conditions?	

Cardiac Intake Form

Select the appropriate option and/or provide an answer to each of the items below:

Have you had any other surgeries?	
Any other treatment history?	
How many times have the patient been pregnant, at what age was the pregnancy, and did the pregnancy result in a live birth?	
Any other medical history that you feel is pertinent for the provider to know?	

FAMILY HISTORY

Family History - Mother	<input type="checkbox"/> Heart issues/disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Stroke <input type="checkbox"/> Unknown <input type="checkbox"/> Other (please specify)
Family History - Father	<input type="checkbox"/> Heart issues/disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Stroke <input type="checkbox"/> Unknown <input type="checkbox"/> Other (please specify)
Family History - Siblings	<input type="checkbox"/> Heart issues/disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Stroke <input type="checkbox"/> Unknown <input type="checkbox"/> Other (please specify)
Additional Family History (if any)	

REVIEW OF SYMPTOMS

Average number bowel movements daily	
Experienced in last 3 mo - Constitutional	<input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Sweats <input type="checkbox"/> Tired <input type="checkbox"/> Weight loss
Experienced in last 3 mo - Head	<input type="checkbox"/> Ear Pain <input type="checkbox"/> Mouth Pain <input type="checkbox"/> Tooth Pain <input type="checkbox"/> Throat Pain <input type="checkbox"/> Poor Hearing <input type="checkbox"/> Nose Discharge
Experienced in last 3 mo - Neuro	<input type="checkbox"/> Headache <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Poor Balance / Coordination <input type="checkbox"/> Urinary / Bowel
Experienced in last 3 mo - Eye	<input type="checkbox"/> Blurred Vision <input type="checkbox"/> Double Vision <input type="checkbox"/> Eye Pain
Experienced in last 3 mo – Muscular/Skeletal	<input type="checkbox"/> Muscle Pain <input type="checkbox"/> Joint Pain
Experienced in last 3 mo - Skin	<input type="checkbox"/> Rash <input type="checkbox"/> Itching <input type="checkbox"/> Bites <input type="checkbox"/> Sores <input type="checkbox"/> Redness
Experienced in last 3 mo - G.I.	<input type="checkbox"/> Belly Pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Constipation
Experienced in last 3 mo - Respiratory	<input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Cough <input type="checkbox"/> Pain <input type="checkbox"/> Wheeze <input type="checkbox"/> Snoring
Experienced in last 3 mo - Genito/Uri	<input type="checkbox"/> Painful / Frequent Urination <input type="checkbox"/> Waking to Urinate <input type="checkbox"/> Periods (F) <input type="checkbox"/> Irregular Periods (F) <input type="checkbox"/> Itching <input type="checkbox"/> Pain <input type="checkbox"/> Discharge (F)
Experienced in last 3 mo - Cardio	<input type="checkbox"/> Chest Pain / Pressure <input type="checkbox"/> Light Headed <input type="checkbox"/> Fluttering in Chest <input type="checkbox"/> Swelling of Legs <input type="checkbox"/> Fainting <input type="checkbox"/> Palpation
Experienced in last 3 mo - Endocrine	<input type="checkbox"/> Often Cold <input type="checkbox"/> Often Hot <input type="checkbox"/> Over Tired <input type="checkbox"/> Over Thirsty
Experienced in last 3 mo - Psych	<input type="checkbox"/> Depression / Feeling Blue <input type="checkbox"/> Anxious <input type="checkbox"/> Trouble Sleeping
Experienced in last 3 mo - Allergy	<input type="checkbox"/> Itchy Eyes <input type="checkbox"/> Sinus <input type="checkbox"/> Sneezing <input type="checkbox"/> Frequent Infection

Cardiac Intake Form

Initial Intake Synopsis

If you feel all your pertinent medical history may need further explanation or you think the provider should be aware of any additional information, please provide us with a synopsis of this information in chronological order (i.e. health timeline, diagnoses, treatments undergone, type of practitioners seen, and etc.) See "Initial Intake Synopsis Example" on next page as reference.

Date: _____

Patient Name: _____

Immune Intake Form

Initial Intake Synopsis Example

If you feel all your pertinent medical history may need further explanation or you think the provider should be aware of any additional information, please provide us with a synopsis of this information in chronological order (i.e. health timeline, diagnoses, treatments undergone, type of practitioners seen, and etc.) See “Initial Intake Synopsis Example” on next page as reference.

Date: _____ Patient Name: _____

September 17, 2009 I had surgery to remove a fibroid. The fibroid was a tumor. My obgyn removed the tumor. left ovary and left fallopian tube. 97% chance tumor would be benign. It was cancer. Very rare tumor. Granulosa cell tumor. I went to MD Anderson for a second opinion. In Kansas City I had 6 rounds (1 every 3 weeks from November 2009 to March 2010) of chemo (carboplatin and Taxol). God blessed us with a miracle! January 2012. we had a healthy baby girl! Because of my history my obgyn asked me to decide if we were having other children and if not do at hysterectomy. November 14, 2012. at 40 I had a my port removed. total hysterectomy. and omentum removed. While removing the omentum they found 3 more nodules. I woke up to my husband telling me they found more nodules and they wanted to do chemo. I knew at that moment chemo did not work and I was not doing it again.

December of 2012, I read the Knock out book by Suzann Somers. We went to Clinic M and to Dr A for a second opinion. Clinic M had never worked with my tumor. Dr A recommended more chemo even when the chemo sensitivity test from Caris results showed no compatible chemo with my tumor. I chose to go a natural approach. March of 2013 I started with Dr. G. I am still on the program. I do coffee enemas twice daily. drink 4 carrot juices daily and take almost 200 pills daily. I soak in the bathtub and do monthly cleanses.

June of 2014 my OBGYN felt something during my annual exam. He requested a CT scan and found 3 masses. My local oncologist used a robot surgery in July of 2014 to remove the masses. We discovered my tumor marker is inhibin B. Every couple months we checked inhibin B after surgery and it continued to go up. Oncologist requested a scan in November of 2014. Found another mass. (I believe the mass was there during surgery but it was too small for Dr. to see).

December of 2014. we were going to try hormonal therapy. I went on Megas for 2 weeks and Tamoxifen for 2 weeks. However, on 2 day of Tamoxifen. I had such terrible pain I went to the emergency room. The ER doctor did a chest X-ray, blood and urine test. All was normal. I stopped taking the pills.

June 28, 2015 I was having terrible pain on my right side and thought I was having an appendicitis. Blood work and urine work showed an infection. CT scan showed 2 masses in my pelvic and “multiple locations suggesting widespread abdominal and peritoneal tumor involvement.” I believe I had gastroenteritis (also mentioned in the CT scan) and that is why my intestines were looped. My husband had a similar infection the week before. I went to my primary doctor 2 days later and they did an X-ray to confirm there was no bowel obstruction and loops were back to normal. I should have gone to a different hospital because this hospital misdiagnosed me in 2009 but I was in pain and went to the closest hospital.

July 14, 2015. my local oncologist did an exam and could feel the tumors. She said it felt like a grapefruit and a pear connected. not sure she could use the robot to remove. Oncologist requested I contact Dr. A for a second opinion and commit to a therapy before she can do surgery.

August 2015 I went to Dr. F in Reno. I was interested to see what their sensitivity test and hair analysis would show.

October 2015. I asked my primary doctor to have my blood tested for inhibin B. my tumor marker. It was 85 in August and is 154. I need a new doctor and a plan to shrink the tumors. I am very interested to hear about your program and if you think it can help me. I appreciated your comments on the Quest for the Cure. I believe God has blessed me every step of the way and I am praying for direction for the next step.

EXAMPLE