



Immune Intake Form

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

OVERVIEW OF HISTORY

Patient's Name & Current Date	
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"/> Minor Child <input type="checkbox"/> Engaged <input type="checkbox"/> Domestic Partner
Patient's Ethnicity	<input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> Indian <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Native American <input type="checkbox"/> Other (please specify)
Patient's Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Intersex / Hermaphrodite
Patient is from (city, state, country)	
How did you hear about our clinic?	
Have you read Dr. Buttar's book and/or watched the "Know Your Options" DVDs?	<input type="checkbox"/> Have read book <input type="checkbox"/> Have NOT read book <input type="checkbox"/> Have NOT watched any of the DVDs <input type="checkbox"/> Have watched DVD: <input type="checkbox"/> 9Steps <input type="checkbox"/> Heavy Metals <input type="checkbox"/> Autism <input type="checkbox"/> Cancer <input type="checkbox"/> Sudden Cardiac Death <input type="checkbox"/> Trans-D Tropin
What is your current Primary Diagnoses?	Type of cancer: Metastasized (spread to other parts): <input type="checkbox"/> Yes <input type="checkbox"/> No
Extent of cancer (Stage 1, 2, 3 or 4)	<input type="checkbox"/> Stage 1 <input type="checkbox"/> Stage 2 <input type="checkbox"/> Stage 3 <input type="checkbox"/> Stage 4

HISTORY OF PRESENT ILLNESS

Date symptoms began (onset of symptoms)	
WHAT was the first evidence of the problem?	
WHEN was first evidence of the problem beginning?	
Summarize pertinent history from initial symptoms to time of diagnosis.	
Date diagnosed	
Who made the diagnosis? (name and type of doctor)	
How was diagnosis made?	<input type="checkbox"/> blood smears <input type="checkbox"/> blood work <input type="checkbox"/> bone biopsy <input type="checkbox"/> bone scan <input type="checkbox"/> core needle biopsy <input type="checkbox"/> colonoscopy <input type="checkbox"/> EGD <input type="checkbox"/> intraprocedural biopsy <input type="checkbox"/> intraoperative biopsy <input type="checkbox"/> needle aspiration biopsy <input type="checkbox"/> spinal tap <input type="checkbox"/> MRI <input type="checkbox"/> CT <input type="checkbox"/> PET scan <input type="checkbox"/> punch biopsy <input type="checkbox"/> surgical excision <input type="checkbox"/> ultrasound <input type="checkbox"/> mammogram <input type="checkbox"/> Other (please specify)
Most recent Pathology/Biopsy/Scan Results	

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

INITIAL SYMPTOMS BEFORE DIAGNOSIS	
Constitutional symptoms prior to diagnosis	<input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> diarrhea <input type="checkbox"/> constipation <input type="checkbox"/> weight change <input type="checkbox"/> appetite change <input type="checkbox"/> fever <input type="checkbox"/> chills <input type="checkbox"/> night sweats <input type="checkbox"/> fatigue <input type="checkbox"/> exhaustion <input type="checkbox"/> weakness <input type="checkbox"/> sleep issues <input type="checkbox"/> pain <input type="checkbox"/> swelling <input type="checkbox"/> discomfort <input type="checkbox"/> joint aches <input type="checkbox"/> muscle aches <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
Habits when initial symptoms began (Select all appropriate options from each section)	<input type="checkbox"/> excellent diet <input type="checkbox"/> good diet <input type="checkbox"/> average diet <input type="checkbox"/> poor diet <input type="checkbox"/> terrible diet <input type="checkbox"/> eating worse than most people <input type="checkbox"/> eating healthier than most people <input type="checkbox"/> eating organic foods <input type="checkbox"/> eating fast food <input type="checkbox"/> eating out frequently <input type="checkbox"/> staying away from sugar <input type="checkbox"/> no change in diet than before symptoms began <input type="checkbox"/> started to diet <input type="checkbox"/> stopped dieting <input type="checkbox"/> optimized diet, balanced with low carb intake ----- <input type="checkbox"/> not exercising <input type="checkbox"/> exercised occasionally <input type="checkbox"/> exercised regularly <input type="checkbox"/> increased level of exercise <input type="checkbox"/> increased level of activity <input type="checkbox"/> level of exercise had not changed <input type="checkbox"/> continued normal level of activity without additional exercise <input type="checkbox"/> decreased level of exercise <input type="checkbox"/> decreased level of activity without additional exercise
Appetite when initial symptoms began	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> No Appetite <input type="checkbox"/> Appetite had decreased over the previous year <input type="checkbox"/> Appetite was normal over the previous year <input type="checkbox"/> Appetite had increased over the previous year <input type="checkbox"/> Felt increased hunger associated with strong desire to eat <input type="checkbox"/> Felt hunger with desire to eat <input type="checkbox"/> Felt a little hunger but without much desire to eat <input type="checkbox"/> Felt hunger but had minimal desire to eat <input type="checkbox"/> Felt a little hunger but without desire to eat <input type="checkbox"/> Felt no hunger and having no desire to eat <input type="checkbox"/> Felt nauseated at the thought of food or eating
SYMPTOMS AT TIME OF DIAGNOSIS	
Constitutional symptoms at time of diagnosis (Select all appropriate options from each section)	<input type="checkbox"/> no significant changes in symptoms <input type="checkbox"/> significant changes in symptoms ----- <input type="checkbox"/> significant improvement of symptoms <input type="checkbox"/> some improvement of symptoms <input type="checkbox"/> some worsening of symptoms <input type="checkbox"/> significant worsening ----- <input type="checkbox"/> increased intensity of symptoms <input type="checkbox"/> decreased intensity of symptoms ----- Symptoms at time of diagnosis included: <input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> diarrhea <input type="checkbox"/> constipation <input type="checkbox"/> weight change <input type="checkbox"/> appetite change <input type="checkbox"/> fever <input type="checkbox"/> chills <input type="checkbox"/> night sweats <input type="checkbox"/> fatigue <input type="checkbox"/> exhaustion <input type="checkbox"/> weakness <input type="checkbox"/> sleep issues <input type="checkbox"/> pain <input type="checkbox"/> swelling <input type="checkbox"/> discomfort <input type="checkbox"/> joint aches <input type="checkbox"/> muscle aches <input type="checkbox"/> Other (please specify)

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

Habits at time of diagnosis (Select all appropriate options from each section)	<input type="checkbox"/> no changes since symptoms began ----- <input type="checkbox"/> excellent diet <input type="checkbox"/> good diet <input type="checkbox"/> significantly improved diet <input type="checkbox"/> average but improved diet <input type="checkbox"/> average diet <input type="checkbox"/> poor but improved diet <input type="checkbox"/> poor diet ----- <input type="checkbox"/> eating worse <input type="checkbox"/> eating better <input type="checkbox"/> eating fast food <input type="checkbox"/> eating out frequently <input type="checkbox"/> eating healthier <input type="checkbox"/> eating organic foods <input type="checkbox"/> eating more raw food <input type="checkbox"/> juicing <input type="checkbox"/> staying away from sugar ----- <input type="checkbox"/> no change in dietary habits <input type="checkbox"/> started to be more conscientious about diet <input type="checkbox"/> went on a specialized dietary intake protocol <input type="checkbox"/> stopped specialized dietary intake protocol <input type="checkbox"/> optimized diet, balanced with low carb intake ----- <input type="checkbox"/> decreased level of activity <input type="checkbox"/> decreased level of activity without additional exercise <input type="checkbox"/> decreased level of exercise <input type="checkbox"/> continued normal level of activity without additional exercise <input type="checkbox"/> did not exercise <input type="checkbox"/> level of exercise did not change <input type="checkbox"/> increased level of activity but without additional exercise <input type="checkbox"/> started to exercise <input type="checkbox"/> continued to exercise regularly <input type="checkbox"/> increased level of exercise
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 <input type="checkbox"/> decreased since initial symptoms <input type="checkbox"/> normal as it had been since initial symptoms <input type="checkbox"/> increased since initial symptoms <input type="checkbox"/> decreased since initial symptoms <input type="checkbox"/> normal as it had been since initial symptoms <input type="checkbox"/> increased since initial symptoms
CURRENT SYMPTOMS AS OF TODAY	
Constitutional symptoms as of today	<input type="checkbox"/> significantly worsened since the time of diagnosis <input type="checkbox"/> worsened since the time of diagnosis <input type="checkbox"/> minimally worsened since the time of diagnosis <input type="checkbox"/> unchanged since time of diagnosis <input type="checkbox"/> minimally improved since initial symptoms began <input type="checkbox"/> improved since initial symptoms began <input type="checkbox"/> significantly improved since initial symptoms began
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"/> Sleep issues <input type="checkbox"/> Swelling <input type="checkbox"/> Discomfort <input type="checkbox"/> Joint Pain <input type="checkbox"/> Muscle Aches <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

Immune Intake Form

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

<p>Habits as of today include (Select all appropriate options from each section)</p>	<ul style="list-style-type: none"> <input type="checkbox"/> no changes since diagnosis <input type="checkbox"/> poor diet <input type="checkbox"/> poor but improved diet <input type="checkbox"/> average diet <input type="checkbox"/> average but improved diet <input type="checkbox"/> significantly improved diet <input type="checkbox"/> good diet <input type="checkbox"/> excellent diet <input type="checkbox"/> eating worse <input type="checkbox"/> eating better <input type="checkbox"/> no fast food <input type="checkbox"/> eating out less frequently <input type="checkbox"/> eating healthier <input type="checkbox"/> stricter food regimen <input type="checkbox"/> eating organic foods <input type="checkbox"/> more raw food <input type="checkbox"/> juicing <input type="checkbox"/> staying away from sugar <p>-----</p> <ul style="list-style-type: none"> <input type="checkbox"/> no change in dietary habits <input type="checkbox"/> started to be more conscientious about diet <input type="checkbox"/> went on a specialized dietary intake protocol <input type="checkbox"/> stopped specialized dietary intake protocol <input type="checkbox"/> optimized diet, balanced with low carb intake <p>-----</p> <ul style="list-style-type: none"> <input type="checkbox"/> decreased level of activity <input type="checkbox"/> decreased level of activity without additional exercise <input type="checkbox"/> decreased level of exercise <input type="checkbox"/> continued normal level of activity without additional exercise <input type="checkbox"/> did not exercise <input type="checkbox"/> level of exercise did not change <input type="checkbox"/> increased level of activity but without additional exercise <input type="checkbox"/> started to exercise <input type="checkbox"/> continued to exercise regularly <input type="checkbox"/> increased level of exercise
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<p>Current appetite (Select all appropriate options from each section)</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> No Appetite <input type="checkbox"/> unchanged since diagnosis <input type="checkbox"/> decreased since diagnosis <input type="checkbox"/> increased since diagnosis <input type="checkbox"/> normal and unchanged since diagnosis <p>-----</p> <ul style="list-style-type: none"> <input type="checkbox"/> Felt increased hunger associated with strong desire to eat <input type="checkbox"/> Felt hunger with desire to eat <input type="checkbox"/> Felt a little hunger but without much desire to eat <input type="checkbox"/> Felt hunger but had minimal desire to eat <input type="checkbox"/> Felt a little hunger but without desire to eat <input type="checkbox"/> Felt no hunger and having no desire to eat <input type="checkbox"/> Felt nauseated at the thought of food or eating
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HISTORY OF TREATMENTS RELATED TO DIAGNOSIS

<p>Surgeries history related to cancer diagnosis (Select all appropriate options from each section)</p>	<ul style="list-style-type: none"> <input type="checkbox"/> surgery was not recommended <input type="checkbox"/> surgery was recommended <input type="checkbox"/> surgery was not an option <p>-----</p> <ul style="list-style-type: none"> <input type="checkbox"/> chose to undergo surgery <input type="checkbox"/> refused to undergo surgery <input type="checkbox"/> currently thinking of having the surgery
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<p>Dates of and type of surgeries history related to cancer diagnosis</p>	
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<p>Chemo history (Select all appropriate options from each section)</p>	<ul style="list-style-type: none"> <input type="checkbox"/> chemo was not recommended <input type="checkbox"/> chemo was recommended <input type="checkbox"/> chemo was not an option <p>-----</p> <ul style="list-style-type: none"> <input type="checkbox"/> chose to undergo chemo <input type="checkbox"/> refused to undergo chemo <input type="checkbox"/> currently thinking of having chemo
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Immune Intake Form

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

Chemo rounds and treatments	_____ Number of rounds of chemo treatments _____ Total number of chemo treatments _____ Date last chemo treatment completed on
Radiation history (Select all appropriate options from each section)	<input type="checkbox"/> radiation not recommended <input type="checkbox"/> radiation recommended <input type="checkbox"/> radiation not an option ----- <input type="checkbox"/> chose to undergo radiation <input type="checkbox"/> refused to undergo radiation <input type="checkbox"/> currently thinking of having radiation
Radiation rounds and treatments	_____ Number of rounds of radiation treatments _____ Total number of radiation treatments _____ Date last radiation treatment completed on
Short description of your condition after surgery, chemo, and/or radiation treatment. How did you feel?	
Tolerance to treatment	<input type="checkbox"/> exceptionally well <input type="checkbox"/> well <input type="checkbox"/> reasonably <input type="checkbox"/> poorly <input type="checkbox"/> terribly <input type="checkbox"/> terribly and could not complete the course of recommended treatment
Complications since diagnosis	
Experiencing any pain? Where?	
Medications currently being taken and purpose	
REVIEW OF SYMPTOMS	
Head/ENT - experienced in last 3 months	<input type="checkbox"/> ear pain <input type="checkbox"/> ear discomfort <input type="checkbox"/> mouth pain <input type="checkbox"/> mouth discomfort <input type="checkbox"/> dental pain <input type="checkbox"/> discomfort in teeth <input type="checkbox"/> throat pain <input type="checkbox"/> throat discomfort <input type="checkbox"/> hearing loss <input type="checkbox"/> ringing in the ears <input type="checkbox"/> nasal discharge
Eye - experienced in last 3 months	<input type="checkbox"/> blurred vision <input type="checkbox"/> double vision <input type="checkbox"/> eye pain <input type="checkbox"/> eye discomfort <input type="checkbox"/> sensitivity to light <input type="checkbox"/> pain on eye movement
Respiratory - experienced in last 3 months	<input type="checkbox"/> shortness of breath <input type="checkbox"/> pain on deep inspiration <input type="checkbox"/> tightness in chest <input type="checkbox"/> coughing <input type="checkbox"/> wheeze <input type="checkbox"/> orthopnea <input type="checkbox"/> dyspnea
Cardio - experienced in last 3 months	<input type="checkbox"/> dull chest pain <input type="checkbox"/> chest heaviness <input type="checkbox"/> squeezing chest discomfort <input type="checkbox"/> light headedness <input type="checkbox"/> fluttering in chest <input type="checkbox"/> swelling of legs <input type="checkbox"/> fainting spells <input type="checkbox"/> heart palpitations
G.I. - experienced in last 3 months	<input type="checkbox"/> abdominal pain <input type="checkbox"/> abdominal cramping <input type="checkbox"/> abdominal distention <input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> diarrhea <input type="checkbox"/> constipation

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

Genito/Uri - experienced in last 3 months (Select all appropriate options from each section)	<input type="checkbox"/> painful urination <input type="checkbox"/> frequent urination <input type="checkbox"/> urgency to urinate <input type="checkbox"/> waking to urinate <input type="checkbox"/> difficulty initiating urinary stream <input type="checkbox"/> problem maintaining urinary stream <input type="checkbox"/> hesitancy while urinating <input type="checkbox"/> inability to empty bladder <input type="checkbox"/> decreased urinary volume --FEMALE-- <input type="checkbox"/> regular menstrual cycles <input type="checkbox"/> irregular menstrual cycles <input type="checkbox"/> heavy menstrual cycles <input type="checkbox"/> painful menstrual cycles <input type="checkbox"/> vaginal itching <input type="checkbox"/> vaginal discharge <input type="checkbox"/> vaginal pain --MALE-- <input type="checkbox"/> penile itching <input type="checkbox"/> penile discharge <input type="checkbox"/> penile pain
Muscular/Skeletal - experienced in last 3 months	<input type="checkbox"/> muscle pain <input type="checkbox"/> muscle weakness <input type="checkbox"/> joint pain <input type="checkbox"/> decrease in range of motion
Neuro - experienced in last 3 months	<input type="checkbox"/> headache <input type="checkbox"/> numbness <input type="checkbox"/> tingling <input type="checkbox"/> right sided weakness <input type="checkbox"/> left sided weakness <input type="checkbox"/> poor balance / coordination <input type="checkbox"/> urinary / bowel incontinence
Psych - experienced in last 3 months	<input type="checkbox"/> depression <input type="checkbox"/> feeling blue <input type="checkbox"/> anxiety <input type="checkbox"/> mood swings <input type="checkbox"/> trouble sleeping <input type="checkbox"/> hallucinations
Endocrine - experienced in last 3 months	<input type="checkbox"/> often being cold <input type="checkbox"/> often being hot <input type="checkbox"/> often being thirsty <input type="checkbox"/> being over tired <input type="checkbox"/> losing hair
Skin – experienced in last 3 months	<input type="checkbox"/> rash <input type="checkbox"/> itching <input type="checkbox"/> hives <input type="checkbox"/> bites <input type="checkbox"/> sores <input type="checkbox"/> redness <input type="checkbox"/> dry skin
Allergy - experienced in last 3 months	<input type="checkbox"/> itchy or watery eye <input type="checkbox"/> runny nose <input type="checkbox"/> draining sinuses <input type="checkbox"/> excessive sneezing <input type="checkbox"/> itching
EXPOSURE HISTORY	
Tobacco Use History (how much, how long, dates used)	
Alcohol use history (type used, how much, how long, dates used)	
Illicit Drug Use History (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	

Immune Intake Form

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

<p>Vaccine History (Select all appropriate options from each section)</p>	<p> <input type="checkbox"/> No history of childhood vaccines <input type="checkbox"/> Full childhood vaccine schedule <input type="checkbox"/> Participated with recommended adult vaccine schedule <input type="checkbox"/> Has abstained from all recommended adult vaccines including flu shot, shingles and pneumonia </p> <p> Has had some recommended adult vaccines, including: <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Haemophilus influenza type b (Hib) <input type="checkbox"/> Human papillomavirus (HPV) <input type="checkbox"/> Influenza <input type="checkbox"/> Measles, mumps, rubella (MMR) <input type="checkbox"/> Meningococcal <input type="checkbox"/> Pneumococcal <input type="checkbox"/> Pneumococcal 13-valent conjugate (PCV13) <input type="checkbox"/> Pneumococcal polysaccharide (PPSV23) <input type="checkbox"/> Poliovirus- Inactivated Rotavirus <input type="checkbox"/> Tetanus, diphtheria, pertussis (Td/Tdap) <input type="checkbox"/> Varicella <input type="checkbox"/> Zoster </p>
<p>How many antibiotics has patient taken in the past year?</p>	
<p>Any amalgams (mercury fillings) removed?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many?</p>
<p>How many amalgams does patient currently have?</p>	
<p>Does patient have a high seafood diet?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
MEDICAL HISTORY	
<p>Have you had any non-cancer related surgeries? Example: gall bladder removed, tonsils removed</p>	
<p>Do you have any other existing medical conditions? Example: Hypothyroid, heart disease, lupus</p>	
<p>Have you undergone any other medical treatments which have not been previously noted?</p>	
<p>How many times has the patient been pregnant, at what age was the pregnancy, and did the pregnancy result in a live birth?</p>	
<p>Do you have any drug, food or environmental allergies or sensitivities?</p>	

Immune Intake Form

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

FAMILY HISTORY

Family History - Mother	<input type="checkbox"/> Living <input type="checkbox"/> Deceased History of: <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"/> Living <input type="checkbox"/> Deceased History of: <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	_____ # of Siblings <input type="checkbox"/> All Living <input type="checkbox"/> All Deceased <input type="checkbox"/> Some Deceased Deceased Siblings had History of: <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)


Immune 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, 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: 10.12.16 Patient Name: Jane Doe

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