

Winning the fight against cancer, every day.®

Cancer Treatment Centers of America® at Eastern Regional Medical Center

In order to prepare for your evaluation and create a personalized treatment plan at Cancer Treatment Centers of America® (CTCA), we will need to collect your past medical records. The information we collect will allow us to review your medical records prior to your appointment at CTCA®. This is necessary to provide you with a thorough medical evaluation from your CTCA treatment team.

Please complete this three-page form to provide us with important contact information from the specific hospitals and physicians with whom you have worked to receive your previous cancer treatment. Please include information from the time of diagnosis through the present time. We will use this information to request copies of your medical records from your providers.

Please complete **all** pages of this medical history form and immediately return to us:

Fax to (215) 537-5116.

If you have any questions, please call (877) 468-2530.

Medical History Form ~ Page 1

Patient Name (Last, First, Middle)		Date of Birth
Previous Name (Due to marriage, adoption or	r other reasons)	
Current Cancer Diagno	osis/Suspected	d Diagnosis:
I was diagnosed with:		
Name of Cancer (For example prostate, breas	t, lymphoma, etc)	Date of Diagnosis (Month/Year)
☐ I have received treatments for this ca☐ I have not yet received treatments for		ction of page 2)
Previous Cancer Diagn	osis:	
I was previously diagnosed with:		
N. C.	t, lymphoma, etc)	Date of Diagnosis (Month/Year)
Cancer Diagnosis – Include physical exams, labs, radiologic scans, bic	e any doctor, hospital or i	medical center that performed testing, helped diagnose any cancers. Please
Cancer Diagnosis – Include	e any doctor, hospital or i	medical center that performed testing, helped diagnose any cancers. Please Hospital Physician Medical Center
Cancer Diagnosis—Include physical exams, labs, radiologic scans, bic use page 3 to share your mammogram ir	e any doctor, hospital or i	helped diagnose any cancers. Please Hospital Physician Medical Center Other
Cancer Diagnosis — Include physical exams, labs, radiologic scans, bicuse page 3 to share your mammogram in Facility/Physician Name City, State Please check the box(s) for testing/di X-ray, PET, CT, Bone Scans, Ultrasounce	le any doctor, hospital or in opsies or office visits that information. Phone Numbing procedures p	helped diagnose any cancers. Please ☐ Hospital ☐ Physician ☐ Medical Center ☐ Other ☐ er ☐ Biopsy ☐ Bloodwork/Labs
Cancer Diagnosis — Include physical exams, labs, radiologic scans, bic use page 3 to share your mammogram in Facility/Physician Name City, State Please check the box(s) for testing/di X-ray, PET, CT, Bone Scans, Ultrasounce	Phone Numb	Hospital
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Cancer Diagnosis — Include physical exams, labs, radiologic scans, bicuse page 3 to share your mammogram in Facility/Physician Name City, State Please check the box(s) for testing/di X-ray, PET, CT, Bone Scans, Ultrasounce Hospital Stay/Overnights	Phone Numb Phone Numb dor MRI Surgery isit/Outpatient Or	Hospital

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Medical History Form ~ Page 2

Patient Name (Last, First, Middle)	Date of Birth
Cancer Treatment — Include any doctor, hospital or medic cancer treatment for this or previous cancers including chemotherapy, rac pain management or other types of treatment. If you have never been treatment.	diation, surgery, naturopathic,
Facility/Physician Name City, State Phone Number	☐ Hospital — ☐ Physician ☐ Medical Center — ☐ Other
Phone Number Please check the box(s) for testing/diagnostic procedures performed at □ X-ray, PET, CT, Bone Scans, Ultrasound or MRI □ Surgery □ □ Chemotherapy □ Radiation □ Naturopathic □ Supplem	Biopsy ☐ Bloodwork/Labs
Facility/Physician Name	☐ Hospital — ☐ Physician ☐ Medical Center ☐ Other
City, State Phone Number	
□ X-ray, PET, CT, Bone Scans, Ultrasound or MRI □ Surgery □ □ Chemotherapy □ Radiation □ Naturopathic □ Supplem	
Facility/Physician Name	☐ Medical Center ☐ Other
City, State Phone Number	
Please check the box(s) for testing/diagnostic procedures perforr ☐ X-ray, PET, CT, Bone Scans, Ultrasound or MRI ☐ Surgery ☐ ☐ Chemotherapy ☐ Radiation ☐ Naturopathic ☐ Supplem	Biopsy ☐ Bloodwork/Labs
□ I have seen additional facilities/physicians for cancer treatment.	
Primary Care Physician — Include the doctor, hospital currently manages your routine health care needs. Physician/Facility Name City, State Phone Number	al or medical center that Hospital Physician Medical Center Other
, and the second	
Date of my last visit with this physician(Month/Year)	

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If you are a male patient and this page does not apply to you, we ask that you still send it back with your name and date of birth at the top.

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Fax to (215) 537-5116.

If you have any questions, please call (877) 468-2530.

Medical History Form ~ Page 3

Patient Name (Last, First, Middle)		Date of Birth
OB/GYN Physician — Inclu manages your female reproductive healti	ide the doctor, hospital or me h care needs. (Female Patien:	edical center that currently ts Only)
Physician/Facility Name		☐ Hospital — ☐ Physician ☐ Medical Center — ☐ Other —
City, State	Phone Number	Li Ottlei
Date of my last visit with this physician .	(Month/Year)	
	(World) real)	
Mammogram — Include your for breast cancer. If you have never had o	most recent mammogram e one, just state "none" on the no	ven if you are not being treatea ame line.
My most recent mammogram was perfo	ormed at:	
		☐ Hospital — ☐ Physician
Physician/Facility Name		— □ Physician □ Medical Center
 City, State	Phone Number	Other
Date of my last mammogram		
	(Month/Year)	
Breast Cancer Patients details from male and female breast cand	cer patients.	ct additional mammogram
details from male and female breast cand	cer patients. I listed previously. ned at the facility listed previo	ously. □ Hospital
details from male and female breast cand Please check one: ☐ I have only had the one mammogram ☐ All of my mammograms were perform	cer patients. I listed previously. ned at the facility listed previo	ously. Hospital Physician Medical Center
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