

Past Medical History and Medications

Age: ____ Race: ____ Sex: ____

Highest Education: _____
_____ < 12 Years
_____ High School Grad
_____ College Graduate
_____ Post-Graduate Degree

Type of Cancer: _____

Date of Diagnosis: _____

Regarding your current diagnosis and cancer treatment:

1. Have you ever utilized alternative therapies to treat your cancer? **Yes** **No**

If yes, what type of therapies have you used? _____

If yes, how long have you been using alternative therapies: _____

If yes, how did you hear about them? _____

2. Have you used any home remedies? **Yes** **No**

If yes, what type(s)? _____

3. Have you utilized any relaxation techniques? **Yes** **No**

If yes, what type(s)? _____

4. Have you utilized massage therapy? **Yes** **No**

5. Do you regularly take any vitamin supplements? **Yes** **No**

If yes, what types? _____

If yes, how often do you take supplements? _____

6. Do you regularly take any herbal or dietary supplements?

If yes, what type(s)? _____

If yes, how often do you take supplements? _____

From the list below, please indicate which, if any, of these products you have taken for the treatment of cancer:

Dehydroepiandrosterone (DHEA)

Grape Seed

Green Tea

Soy or Genistein

Echinacea

Chaparral

Flaxseed

Pau d'arco, Lapacho or Taheebo

Shark Cartilage

Mistletoe (*Isador*)

Huang Ch'i

Milk Thistle

Other: _____

Other: _____

7. Has your doctor or anyone else recommended any of the above treatment or therapies? **Yes** **No**

If yes, who? _____

8. Have you talked with your cancer doctor about alternative or complementary therapies? **Yes** **No**

9. How many servings of fruits and vegetables do you have each day? ___1 ___2 ___3 ___4 ___5 ___>5

If you have cancer now, how many servings of fruits and vegetables did you have each day *before* you were diagnosed with cancer? ___1 ___2 ___3 ___4 ___5 ___>5