DOCRATES
CANCER CENTER

Preliminary Information Form

Please fill in this preliminary information form before the first doctor's appointment at Docrates Cancer Center. This information is needed for examinations and treatment planning as well as for its implementation. Thank You!

Name			
Social security number			
Street address			
Postal code		**City and country**	
Phone (home)		**Mobile phone**	
E-mail			
Occupation			
Name of the next of kin			
Phone of the next of kin		**E-mail of the next of kin**	

Based on recent findings, smoking can affect the metabolism and concentration of certain cancer drugs, and therefore also the response to treatment with some drugs.		
Do you smoke?	☐ no ☐ yes	Amount (e.g. pacs/day)?
When or at which age you started smoking?		When or at which age did you stop smoking?
Use of alcohol		☐ none ☐ average ____ per week
Vaccinations – has there been any exceptions from the official vaccination schedule?		
Year of the most recent tetanus vaccine (booster) injection?		

Cancer among the family / relatives (children, siblings, parents, grandparents)	(Specify cancer among the family here: diagnosis and age)	
Medications in use with dosages (continue to the reverse side if needed)	**Product name**	**Dosage per day and duration of use**
Allergies (especially drug allergies)		
Vitamins, minerals and natural remedies being used		
For women: age at start/end of menstruation, number and time of pregnancies (years)		
The use of oral contraceptives	☐ none ☐ Contraceptive pills (use in years ______	

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(CONTINUATION OF THE FIRST PAGE)

Hormone replacement therapy	☐ actual ☐ in use during years:______
Height (cm)	**Weight (kg)**

Do you currently have or have you had earlier the following diseases? (mark the ones you have with a cross (x) and specify)

☐ paralysis, specify______________________
☐ neuromascular disease, specify______________________
☐ skin disease, specify______________________
☐ lung disease, specify______________________
☐ thyroid gland disease, specify______________________
☐ ear disease or hearing loss, specify ______________________
☐ thrombosis or pulmonary thromboembolism
☐ stomach or intestinal disease, specify______________________
☐ liver or pancreas disease, specify ______________________
☐ kidney disease, specify______________________
☐ neurological disorder, specify ______________________
☐ rheumatoid arthritis or other type of joint disease, specify ______________________
☐ malignant tumor, cancer ______________________
☐ mental disorder, specify ______________________
☐ eye disease, specify______________________
☐ diabetes
☐ heart disease, specify ______________________
☐ locomotive or musculo-skeletal disorder, specify______________________
☐ recurring headache or migraine
☐ hypertension
☐ higher risk of bleeding
☐ urinary disease, specify______________________
☐ other disease, specify______________________

Choose the correct answers for the following questions (mark with a cross (x) and specify)

No	Yes	
☐	☐	Do you have or have you had earlier blood infections or other infections? (HIV, hepatitis, MRSA)? Which?____
☐	☐	Have you stayed in a hospital in Finland or outside Finland during the past 6 months ?
☐	☐	Are you currently or have you been earlier working in a hospital? Where and when? ____________________________
☐	☐	Have you had MRSA test? Where and when?____________________________

Signature

Place and date: __________________________________ _____ / _____ / 20_____

____ ____

Signature (for under 18 y.o. signs the parent) Name