Cancer Treatment Centers of America®

Winning the fight against cancer, every day.®

Cancer Treatment Centers of America® at Midwestern 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 (847) 746-6584 or (847) 746-7175.

If you have any questions, please call (888) 881-6762.

Medical History Form ~ *Page 1*

Patient Name (Last, First, Middle) _____ Date of Birth _____

Previous Name (Due to marriage, adoption or other reasons) _____

Current Cancer Diagnosis/Suspected Diagnosis:

I was diagnosed with:

Name of Cancer (For example prostate, breast, lymphoma, etc) _____ Date of Diagnosis (Month/Year) _____

☐ I have received treatments for this cancer.
☐ I have not yet received treatments for this cancer. (Skip top section of page 2)

Previous Cancer Diagnosis:

I was previously diagnosed with:

Name of Cancer (For example prostate, breast, lymphoma, etc) _____ Date of Diagnosis (Month/Year) _____

Cancer Diagnosis–*Include any doctor, hospital or medical center that performed testing, physical exams, labs, radiologic scans, biopsies or office visits that helped diagnose any cancers. Please use page 3 to share your mammogram information.*

Facility/Physician Name _____ Date _____

City, State _____ Phone Number _____

☐ Hospital
☐ Physician
☐ Medical Center
☐ Other _____

Please check the box(s) for testing/diagnostic procedures performed at this facility:

☐ X-ray, PET, CT, Bone Scans, Ultrasound or MRI ☐ Surgery ☐ Biopsy ☐ Bloodwork/Labs
☐ Hospital Stay/Overnights ☐ ER Visit/Outpatient ☐ Other _____

Facility/Physician Name _____ Date _____

City, State _____ Phone Number _____

☐ Hospital
☐ Physician
☐ Medical Center
☐ Other _____

Please check the box(s) for testing/diagnostic procedures performed at this facility:

☐ X-ray, PET, CT, Bone Scans, Ultrasound or MRI ☐ Surgery ☐ Biopsy ☐ Bloodwork/Labs
☐ Hospital Stay/Overnights ☐ ER Visit/Outpatient ☐ Other _____

☐ I have seen additional facilities/physicians for cancer diagnosis.

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Medical History Form ~ *Page 2*

Patient Name (Last, First, Middle) _____ Date of Birth _____

Cancer Treatment – *Include any doctor, hospital or medical center that performed cancer treatment for this or previous cancers including chemotherapy, radiation, surgery, naturopathic, pain management or other types of treatment. If you have never been treated you may skip this section.*

Facility/Physician Name _____ Date _____

City, State _____ Phone Number _____

☐ Hospital
☐ Physician
☐ Medical Center
☐ Other _____

Please check the box(s) for testing/diagnostic procedures performed at this facility:

☐ X-ray, PET, CT, Bone Scans, Ultrasound or MRI ☐ Surgery ☐ Biopsy ☐ Bloodwork/Labs
☐ Chemotherapy ☐ Radiation ☐ Naturopathic ☐ Supplements ☐ Other _____

Facility/Physician Name _____ Date _____

City, State _____ Phone Number _____

☐ Hospital
☐ Physician
☐ Medical Center
☐ Other _____

Please check the box(s) for testing/diagnostic procedures performed at this facility:

☐ X-ray, PET, CT, Bone Scans, Ultrasound or MRI ☐ Surgery ☐ Biopsy ☐ Bloodwork/Labs
☐ Chemotherapy ☐ Radiation ☐ Naturopathic ☐ Supplements ☐ Other _____

Facility/Physician Name _____ Date _____

City, State _____ Phone Number _____

☐ Hospital
☐ Physician
☐ Medical Center
☐ Other _____

Please check the box(s) for testing/diagnostic procedures performed at this facility:

☐ X-ray, PET, CT, Bone Scans, Ultrasound or MRI ☐ Surgery ☐ Biopsy ☐ Bloodwork/Labs
☐ Chemotherapy ☐ Radiation ☐ Naturopathic ☐ Supplements ☐ Other _____

☐ I have seen additional facilities/physicians for cancer treatment.

Primary Care Physician – *Include the doctor, hospital or medical center that currently manages your routine health care needs.*

Physician/Facility Name _____

City, State _____ Phone Number _____

☐ Hospital
☐ Physician
☐ Medical Center
☐ Other _____

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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Medical History Form ~ *Page 3*

Patient Name (Last, First, Middle) _____ Date of Birth _____

OB/GYN Physician – *Include the doctor, hospital or medical center that currently manages your female reproductive health care needs. (Female Patients Only)*

Physician/Facility Name _____

City, State _____ Phone Number _____

☐ Hospital
☐ Physician
☐ Medical Center
☐ Other _____

Date of my last visit with this physician _____ (Month/Year)

Mammogram – *Include your most recent mammogram even if you are not being treated for breast cancer. If you have never had one, just state "none" on the name line.*

My most recent mammogram was performed at:

Physician/Facility Name _____

City, State _____ Phone Number _____

☐ Hospital
☐ Physician
☐ Medical Center
☐ Other _____

Date of my last mammogram _____ (Month/Year)

Breast Cancer Patients Only – *We need to collect additional mammogram details from male and female breast cancer patients.*

Please check one:

☐ I have only had the one mammogram listed previously.
☐ All of my mammograms were performed at the facility listed previously.
☐ I have had additional mammograms performed at the following:

Facility/Physician Name _____

City, State _____ Phone Number _____

☐ Hospital
☐ Physician
☐ Medical Center
☐ Other _____

Mammogram Dates _____ (Month/Year)

Facility/Physician Name _____

City, State _____ Phone Number _____

☐ Hospital
☐ Physician
☐ Medical Center
☐ Other _____

Mammogram Dates _____ (Month/Year)

Facility/Physician Name _____

City, State _____ Phone Number _____

☐ Hospital
☐ Physician
☐ Medical Center
☐ Other _____

Mammogram Dates _____ (Month/Year)

☐ I have seen additional facilities/physicians for mammograms.

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