



## CANCER CENTER FOR HEALING

### MEDICAL QUESTIONNAIRE

Please fill out the medical questionnaire below. Once completed, please save and return as an attachment by email to [REDACTED]. Once Dana receives the information she will contact you to arrange a consultation with one of our Cancer Team Doctors. After the consult we will customize a treatment plan.

**INSURANCE INFORMATION:** Please provide Cancer Center For Healing with a front and back copy of your insurance card so we can verify coverage prior to your consultation.

**NOTE\*:** In lieu of medical records, please send all pertinent scan reports (MRI, Ultrasounds, PET) and all pertinent labs taken in the last 3 months to [REDACTED]. We do not accept records on CDs, please provide us with a word or PDF document.

<b>Patient Name:</b>	Jeffrey Epstein
<b>DOB:</b>	Jan. 20, 1953
<b>Age:</b>	63
<b>Sex:</b>	Male
<b>Home Phone:</b>	212 750 9895
<b>Cell Phone:</b>	212 533 3739
<b>Who do we contact to set up the consultation (name &amp; phone number):</b>	Lesley [REDACTED]
<b>Email:</b>	[REDACTED]
<b>Home Address:</b> Street, City, State & Zip	9 East 71 <sup>st</sup> Street New York, New York 10021
<b>Date of Cancer Diagnosis:</b>	
<b>Type of Cancer (Pathology Diagnosis):</b>	

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<b>Cancer Stage:</b>	
<b>Have you received Chemo? What dates did you receive treatment?:</b>	
<b>Have you received Radiation? What dates did you receive treatment?:</b>	
<b>Have you had surgery to treat your cancer? What date(s) did you have the surgery(s) on?</b>	
<b>Any Complications from previous treatments?:</b>	
<b>Date of last bloodwork:</b>	
<b>Date of last PET Scan:</b>	
<b>Therapies currently receiving for psychological/emotional wellbeing:</b>	
<b>Father's medical history:</b>	

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Direct: (949) 581-HOPE | Fax: (949) 606-893



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<b>Mother's medical history:</b>	
<b>Family medical history:</b>	
<b>Do you have a history of smoking or drinking?</b>	
<b>Have you ever been hospitalized? What was your diagnosis? What dates were you in the hospital?</b>	
<b>What is your dental history? Any major procedures</b>	
<b>Are you in pain?:</b>	
<b>Specify type of pain on a scale from 1 to 10:</b>	
<b>Pain medication type and dosage:</b>	
<b>When do you plan to start treatment with Cancer Center For Healing?:</b>	
<b>How did you hear about Cancer Center For Healing?:</b>	

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<b>Additional information we should know:</b>	
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