Salish CANCER CENTER

The Puyallup Tribe's Integrative Approach to Healing

In order to prepare for your evaluation and create a personalized treatment plan at Salish Cancer Center, 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 SCC. This is necessary to provide you with a thorough medical evaluation from your SCC treatment team.

Please complete this two-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 history form prior to your appointment. You can either fax it in advance of your appointment to:

253-382-6301

or bring it with you to your first appointment.

Medical History Form - 1 of 2

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 received treatment 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 _____

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 _____

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 - 2 of 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

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

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

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 ______

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

Facility / Physician Name

City, State Phone Number

Date of my last visit (Month / Year)

☐ Hospital
☐ Physician
☐ Medical Center
☐ Other ______