Puget Sound Family Health and apothecary

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Cancer History Intake:

Cancer type & location: _____

Date of diagnosis: _____

Tumor size: _____

Stage & Grade: _____

Medical Oncologist: _____

Breast cancer only:

Estrogen Receptor: ◯ positive / ◯ negative (percent if known_____)

Progesterone Receptor: ◯ positive / ◯ negative (percent if known_____)

HER2neu status: ◯ positive / ◯ negative

Was OncoType Dx testing done? ◯ yes / ◯ no

Treatment history:

Surgery and dates: _____

Chemotherapy (list agents if known): _____

Radiation: ◯ yes / ◯ no

Hormone therapy: _____

Supplements: _____

Other: _____

By signing below, you agree to the following: I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Printed Name: _____

Signature: _____ Date: _____

☐ **By checking this box, I acknowledge that I am signing electronically.**