

13. Job profile – Self owned Business / Job / House wife / Student / Retirement Fill the following details -
(present job and previous job)

Sr. No	Occupation	Nature sedentary/ shift duties/ travelling / trading / professional/ intellectual	Duty hours	Total Duration

14. Details about History of Past illness (other than cancer) –

a. Details of your birth delivery – Normal / Caesarean / Forceps /At home / At Hospital Any complications –

b. Previous Surgery details if any–

Sr. No	Name of Surgery	Reason for surgery	Doctor / Hospital Name

c. Any trauma / accidents /fractures–

Sr. No	Type of trauma / accident / fractures	Time of occurrence	Treatment taken	Any Deformity remained Yes/No Type of deformity

d. Past Diseases –

Sr. No	Name of Disease	Time of occurrence	Treatment taken

15. Details about any present disease (like hypertension, diabetes, thyroid problem, etc other than cancer) and details of medicines for it –

Sr. No	Name of Present Disease	Time of occurrence	Ongoing Treatment (Mention the names of medicines with dose)

16. Family History –

	Relation	Age of relative at time of diagnosis	Cancer		Other diseases (other than cancer)
			Same site	Other site	
Maternal side					
Paternal side					
Same generation (sister / brother)					
Next generation (children)					

Cancer Related History

17. Details about Cancer / metastasis / recurrence –

Details about Primary Cancer		
Site	Time of occurrence	Treatment – previous and ongoing (in short)
Details about Recurrence, if occurred		
Site	Time of occurrence	Treatment – previous and ongoing (in short)
Details about Metastasis, if occurred		
Site	Time of occurrence	Treatment – previous and ongoing (in short)

18. Cancer related history in the form of signs and symptoms-

Sr. No		Signs & Symptoms / Complaints
1	During diagnosis	
2	After cancer treatment, whether signs subsided or increased	
3	During metastasis, if present	
4	During recurrence, if present	
5	Present complaints	

d. Oral chemotherapy / Hormonal treatment details -

Oral Chemotherapy				
Medicine name with dose	Started from (Date)	Taken till (Date)	Side - effects	Name of Oncologist / Hospital
Hormonal Treatment				
Medicine name with dose	Started from (Date)	Taken till (Date)	Side - effects	Name of Oncologist / Hospital

20. Addictions –

Sr. No	Addiction	Quantity	Frequency	Duration
1	Alcohol			
2	Smoking			
3	Narcotics			
4	Others –			

21. General information -

Sr. No		Present	Past
1	Appetite		
2	Digestion		
3	Stools / bowel habits		
4	Urine habits		
5	Sleep		
6	Tendency of worms		
7	Weight		
8	B.P		

22. Emotional status –

- 1. Nature** – Calm / Angry / Aggressive /Pessimist / Optimist / Fearful
- 2. Mental stress if any** - Physical / Financial / Mental / Professional / Social / Family related
- 3. Duration of stress** -
- 4. Change in behavior after diagnosis of Cancer** –

23. Daily water intake –

- a. Do you drink water only when you are thirsty or whether you are habituated to drink water –
- b. Type of water – Corporation water/ Borewell water/ Well water/ Tanker water/Aquaguard /Cold water/ Boiled water/ Spring water

Sr. No	Time of water intake	Quantity (in glass)	Seasonal variation
1	Early morning, empty Stomach		
2	Before meals		
3	In between meals		
4	After meals		
5	Before going to sleep at night		
6	During night time		
7	Other specific times		
8	Total water intake (per day)		

24. Present Diet -

Time	Food items	Quantity	Any special information
Early morning drinks / water			
Breakfast			
Lunch			
Evening snacks			
Dinner			
In between food stuffs – If any			
Drinks – like Pepsi, Coca cola, Coffee, Milk			
Specific food items – like Chocolate, Ice -cream, Yogurt, Fruit Yogurt, Milk shakes, Chips, Chinese noodles, Pizza			

25. Past diet -

Fond of – Sweet / Sour/ Salty / Pungent / Bitter / Astringent
Hot food / Cold food

Food items	Quantity	Frequency – Per day / per week / per month
Sweet		
Sour		
Salty		
Pungent		
Bitter		
Astringent		

For Female patients only

MENSTRUAL HISTORY		
Sr. No		
1	Onset	
2	Menstrual flow – Regular / Irregular	
3	Flow - Scanty / Heavy / Painful / Absence of menstruation / Presence of clots	
4	Specific odour	
5	Symptoms before or during Menstrual cycle – Stomach pain, Backache, Leg pain, etc	
6	Duration of menstrual cycle --- days/	
7	Menopause age	
	Pre-menopausal symptoms, if any	
	Treatment if taken	
8	Leucorrhoea (White discharge) Yes / No	
	Color of discharge – Yellow / greenish / white	
	Consistency – watery / normal / sticky	
	Whether accompanied with itching or burning sensation around vaginal area	
9	Age during marriage	
	Number of marriages	
10	Any other details	

OBSTETRICS HISTORY		
Sr. No		
1	Age during first pregnancy	
2	Age when gave birth to first child	
3	Number of child births with gender	
4	Normal delivery / Caesarean section / Forcep delivery	
5	Pre- mature delivery / Full term delivery	
6	Miscarriages / Abortions	
7	Treatment if taken for pregnancy	
8	Any diseases occurred during pregnancy	
9	Use of contraceptives with duration , specify Pills / Copper T / Tubectomy / Cu T etc.	
10	Weaning done – Yes / No	
11	Duration of Weaning	
12	Milk secretion – scanty / excess / proportionate	
13	Any other details	