



MAINTRAC MEDICAL QUESTIONNAIRE

To complete this form on your computer, please use free Adobe PDF Reader:

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PERSONAL INFORMATION	
First Name: _____	Last Name: _____
Sex: ☐ M ☐ F	
Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other _____	
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Wid. ☐ Other _____	
Street: _____	Unit # _____
City: _____	State/Prov: _____ Country: _____
Postal Code: _____	
Home phone: _____	Work Phone: _____
Cell phone: _____	Fax number: _____
5. Email address: _____	
6. Date of birth: (day/month/year) _____	
7. Health card number: _____ VC: _____ Health card province: _____ (for Canadian patients only)	
8. Do you have private health insurance? ☐ Yes ☐ No ☐ Not sure	
9. Who should be contacted in case of emergency?	
Name: _____	Relationship: _____
Contact numbers: _____	
10. Second language (optional): _____	
11. Religion (optional): _____	

Revised Oct 25, 2017

CANCER HISTORY SUMMARY

What type of cancer do you have?

How was it diagnosed?	Diagnosis date:
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Diagnosis date:

Was a biopsy obtained?	☐ Yes	☐ No	☐ Not sure
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☐ Not sure☐ Not sure☐ Not sure

What treatments have you received?

Chemotherapy ☐ Yes ☐ No ☐ Not yet, starting soon ☐ Not sure

☐ Not sure☐ Not sure☐ Not sure

Radiation therapy ☐ Yes ☐ No ☐ Not yet, starting soon ☐ Not sure

☐ Not sure☐ Not sure

Surgery ☐ Yes ☐ No ☐ Not yet, starting soon ☐ Not sure

☐ Not sure☐ Not sure

Experimental therapy ☐ Yes ☐ No ☐ Not yet, starting soon ☐ Not sure

☐ Not sure☐ Not sure

Natural therapy ☐ Yes ☐ No ☐ Not yet, starting soon ☐ Not sure

☐ Not sure☐ Not sure

CANCER HISTORY DETAILS

Please describe **briefly** what happened that led to the diagnosis of cancer.

[illegible]

Please describe **briefly** the sequence of treatment(s), response(s), recurrence(s).

[illegible]

PAST MEDICAL HISTORY

Health problems other than cancer, or any operations?

Health Problems / Operations**Approximate date(s)**

Did you receive one or more COVID-19 mRNA injections?

Approximate date(s)

MEDICATIONS – CONVENTIONAL and NATURAL

Please list all of your **current medications and supplements** (name, dose and how often you take them). If you are not sure of the dose, please just list the name(s).

Name	Dose	How often

ALLERGIES / ADVERSE REACTIONS

Have you ever had an **allergy** or **adverse reaction** to any of the following?

Category	Yes √	No √	Please list
Drugs	☐	☐	
Foods	☐	☐	
Others (pollen, grass, pets, etc.)	☐	☐	

HEALTH CARE INFORMATION

Please provide the following information about your health care providers:

Specialty	Name	Phone Number	Hospital
Family doctor			
Naturopathic doctor			
Other			

Would you like any of your doctors informed about your treatment with us?

Name: _____

Fax: _____ Email: _____

MEDICOR

As per Medicor Privacy Policy, we do not give confidential information over the phone. If such a request is made, we may require correct answers to some questions before giving out any information. This is only for your protection. In order to do this, please provide answers to the following questions:

a. Place of birth _____

b. Favourite colour _____

How did you find out about us?

Signature:

Date: _____