Cancer-Specific Medical Questionnaire

Personal Information

Full Name

Date of Birth

Gender

Select

Contact Number

Medical History

Have you ever been diagnosed with any form of cancer?

Yes No

If yes, please specify the type(s) of cancer:

Date of diagnosis:

Stage of cancer at diagnosis:

Select

Current status:

Select

List all treatments received (surgery, chemotherapy, radiotherapy, others):

Date of last treatment (if any):

Have you experienced any recurrence or metastasis?

Yes No

Are you currently taking any medication related to cancer? If yes, please specify:

Family History

Any history of cancer in immediate family members?

- Yes
- No

If yes, please specify relationship(s) and type(s) of cancer:

Other Relevant Information

Do you have any other existing medical conditions?

Additional notes or comments: