**Patient extended application form**

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| 1. | Name, surname |  |
| 2. | Date of birth |  |
| 3. | Address |  |
| 4. | Country |  |
| 5. | Phone number |  |
| 6. | E-mail |  |
| 7. | Current diagnosis |  |
| 8. | Duration of illness |  |
| 9. | Current tumor size, location and spread |  |
| 10. | Other significant comorbidities |  |
| 11. | Intolerance of medication |  |
| 12. | Therapy received in the last year or months |  |
| 13. | Regularly used medications |  |

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| 14. | What dietary supplements are you currently taking? |  |
| 15. | Is there a special diet recommended for you and what foods do you avoid? |  |
| 16. | Are you currently employed? |  |
| 17. | Your profession |  |
| 18. | Are you currently on sick leave? |  |
| 19. | How far can you walk without the help of others (m / km)? |  |
| 20. | Are you able to take care of yourself? |  |
| 21. | Can you climb stairs? |  |
| 22. | Are you short of breath when you walk? |  |
| 23. | Do you need assistance when walking on a horizontal surface? |  |
| 24. | Have you had fluid build-up in your abdomen or pleura? |  |
| 25. | Do you have a trouble falling asleep? |  |
| 26. | Do you take sleeping pills? |  |
| 27. | What are the main complaints about your health currently? Please describe in detail! |  |
| 28. | Did you have any blood transfusion? |  |
| 29. | In case you had a blood transfusion, how many times and when did you last have it? |  |
| 30. | Do you have bowel problems? (constipation or diarrhea) |  |
| 31. | Do you have urinary problems? |  |
| 32. | Do you have any problems with pain? |  |
| 33. | What pain medication are you taking? |  |

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| 34. | Is your pain problems constant or episodic? |  |
| 35. | Please indicate the name and dosage of the prescribed painkillers |  |
| 36. | Is there a need to adjust pain medication? |  |
| 37. | What is your height and weight? |  |
| 38. | Do you currently have a non-healing wounds? |  |
| 39. | What type of therapy would you like to receive in our clinic (infusions, hyperthermia, physical therapy)? |  |
| 40. | What therapy is planned after the course of treatment in our clinic? |  |
| 41. | Why did you choose the treatment at our clinic? |  |
| 42. | How did you find our clinic? |  |
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| Thank you for the answers.  Send this application form to our e-mail: **info@santamonica.lv**  We will contact you as soon as possible. | | |