Tokyo Midtown Center for Advanced Medical Science and Technology
Midtown Tower 6F, 9-7-1 Akasaka, Minato-ku, Tokyo (JAPAN)
Tel. : +81-3-5413-7920 ・Fax: +81-3-5413-0322

Patient Assessment Form

I. Please fill in the followin			
Patient Name	First name	Family name	
Date of Birth		Gender	Male / Female

Cancer Type / Metastasis	
Pathological Diagnosis	
Stage (If known)	
Medical History	Information of primary physician for the treatment of cancer: Institution ……. Department …… Doctor …….. Does your primary physician approve to be treated with immunotherapy? ☐Yes ☐No Can we contact your physician to inquire about your medical information? ☐Yes ☐No ☐ First Diagnosis of cancer Year: …….. Month:……..
Surgical history (cancer specific)	
Radiotherapy (when, to which part of body)	
Chemotherapy (name of medication, dosage, duration)	
Other cancer treatment (steroids/hormonal medicine, etc.)	
Any previous or current use of immune-checkpoint inhibitors? (Nivolumab, Yervoy, etc.)	☐Yes ☐No If yes, please describe when, which medication, how long.

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Other medical conditions	Circle 'Yes' or 'No' ☐Diabetes ☐Heart disease ☐High blood pressure ☐Cerebral infarction ☐Stomach/Duodenal ulcer ☐Allergies ☐Pacemaker ☐Implanted port ☐Other (please specify)	Yes ・ No Yes ・ No Yes ・ No Yes ・ No Yes ・ No Yes ・ No Yes ・ No Yes ・ No	Medication taken. ……. ……. ……. ……. ……. ……. ……. ……. …….
Current medications	Please list all medication and supplements taken: Are you taking anticoagulant? Yes ・ No Are you taking anti-diabetic or insulin shots? Yes ・ No Are you taking any pain killer? Yes ・ No Are you taking any hormonal treatment / steroids? Yes ・ No		
Smoking	☐No ☐Currently smoke ( ) cigarettes a day ☐Quit ( ) years ago		
Drinking	☐Not at all ☐Occasionally ☐Very often ☐Used to drink but quit ( ) years ago		
Appetite	Do you have any changes in your appetite? ☐No change ☐Slightly reduced ☐Reduced a lot Do you have any changes in your weight? ☐No ☐Yes, …...kg within …..months Height: ……cm Weight: ……kg		

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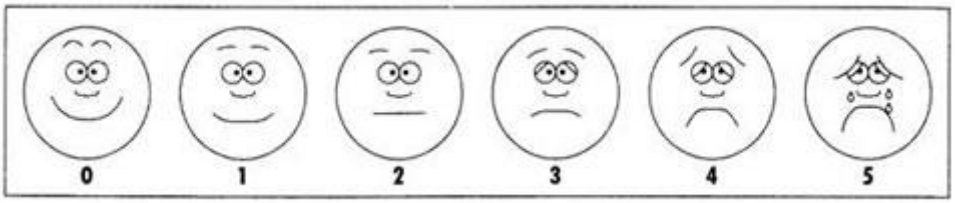
Pain assessment (Please choose the face number that best describes the patient's pain condition)



0: no pain 1: mild pain 2: moderate pain 3: severe pain 4: very severe pain 5:worst possible pain

Performance status (Please choose the number which best describes the patient's current status)

0: fully active, able to carry on all pre-disease performance without restriction
1: restricted in physically strenuous activity but ambulatory and able to carry out work of light and sedentary nature, such as household chores and office work
2: ambulatory and capable of all self-care but unable to carry out any work activities, up and about more than 50% of working hours
3: capable of only limited self-care, confined to bed or chair more than 50% of working hours
4: completely disabled. Cannot carry on self-care. Totally confined to bed or chair.

Difficulty breathing?	☐ No ☐ Yes Are you on oxygen? ☐Yes (…….L/day) ☐No
Who will the patient be accompanied for the consultation?	

Please list any questions that you wish to inquire during the medical consultation.