

## CLIENT INTAKE SHEET – ZANTAC (RANITIDINE)

Did you ingest Zantac (Ranitidine)?\* Yes  No

Did you take the brand or generic form of Zantac (Ranitidine)? \_\_\_\_\_

When did you take Zantac? \_\_\_\_\_ For how long? \_\_\_\_\_

Were you diagnosed with cancer?\* Yes  No

If so, which type of cancer were you diagnosed with? *(Please check all that apply.)*

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Bladder cancer          | <input type="checkbox"/> Kidney cancer             | <input type="checkbox"/> Stomach cancer    |
| <input type="checkbox"/> Brain cancer            | <input type="checkbox"/> Liver cancer              | <input type="checkbox"/> Testicular cancer |
| <input type="checkbox"/> Colon and Rectal cancer | <input type="checkbox"/> Lung cancer (non-smokers) | <input type="checkbox"/> Thyroid cancer    |
| <input type="checkbox"/> Esophageal cancer       | <input type="checkbox"/> Ovarian cancer            | <input type="checkbox"/> Uterine cancer    |
| <input type="checkbox"/> Intestinal cancer       | <input type="checkbox"/> Pancreatic cancer         |  |
| <input type="checkbox"/> Kidney cancer           | <input type="checkbox"/> Prostate cancer           |  |

Please provide details: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### PERSONAL INFORMATION

First Name\*: \_\_\_\_\_ Last Name\*: \_\_\_\_\_

Email\*: \_\_\_\_\_

Confirm Email\*: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

Street Address\*: \_\_\_\_\_

City\*: \_\_\_\_\_ State\*: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Best time to reach you: \_\_\_\_\_

*\* required fields*