

Current Diagnosis:

Diagnosed By:

Type of Cancer:	Stage:	Date Diagnosed:	
Oncologist:	Facility:		
Address:	City:	State:	Zip:
Phone:		Fax:	

RECORD OF DIAGNOSTIC TESTING

Type (biopsy, scan, surgery)	Date/Location	Results

GENETIC TESTING

Date of Test	Location	Test Type	Results

Previous Cancer History (Make more copies if needed)

Type of Cancer:	Stage:	Date Diagnosed:	
Oncologist:	Facility:		
Address:	City:	State:	Zip:
Phone:		Fax:	

Previous Cancer History

Type of Cancer:	Stage:	Date Diagnosed:	
Oncologist:	Facility:		
Address:	City:	State:	Zip:
Phone:		Fax:	

Previous Cancer Treatment (Make more copies if needed)

Chemotherapy Surgery Radiation Hormone Therapy Immunotherapy Other _____

Dates:

Facility/Doctor:

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Additional Details: Treatment received, drug names/dosage received, type of surgery/outcome, duration in hospital, complications, etc.

Previous Cancer Treatment

Chemotherapy Surgery Radiation Hormone Therapy Immunotherapy Other _____

Dates:

Facility/Doctor:

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Additional Details: Treatment received, drug names/dosage received, type of surgery/outcome, duration in hospital, complications, etc.

Previous Cancer Treatment

Chemotherapy Surgery Radiation Hormone Therapy Immunotherapy Other _____

Dates:

Facility/Doctor:

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Additional Details: Treatment received, drug names/dosage received, type of surgery/outcome, duration in hospital, complications, etc.

CURRENT/PAST HEALTH CONDITIONS (Check all that apply)

Current	Past	Condition	Notes	Current	Past	Condition	Notes
		Allergies				Kidney/Urine Problems	
		Arthritis				Liver Problems	
		Blood Disorder				Lung Problems	
		Circulation Problems				Prostate Problems	
		Depression/Anxiety				Seizures/Epilepsy	
		Diabetes				Skin Disorders	
		Frequent Infections				Shingles	
		Gastrointestinal Problems				Stroke	
		Gynecological Problems				Thyroid Problems	
		Heart Problems				Tuberculosis	
		Hepatitis				Ulcers	
		High Blood Pressure				Other	
		HIV/AIDS				Other	

List past surgeries and hospitalizations. (Make more copies if needed)

Date	Surgery	Location	Outcome

FAMILY HISTORY List relatives who have had a serious illness. Indicate disease & age of onset. (example: cancer, heart disease, diabetes)

Biological Father	Notes:	Biological Mother	Notes:
Paternal Grandfather	Notes:	Maternal Grandfather	Notes:
Paternal Grandmother	Notes:	Maternal Grandmother	Notes:
Paternal Uncle	Notes:	Maternal Uncle	Notes:
Paternal Aunt	Notes:	Maternal Aunt	Notes:
Sibling	Notes:	Sibling	Notes: