MY MEDICAL INFORMATION

Clear Form

Date Completed:_____

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 and 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: