MY MEDICAL INFORMATION

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).

	Relative	Notes		Relative	Notes
	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:

MY HEALTHCARE CONTACTS

EMERGENCY CONTACT #1

Name:	Relationship:

Address:

City:	State:	Zip:

Phone #1:	Phone #2:

Email:

EMERGENCY CONTACT #2

Name:	Relationship:

Address:

City:	State:	Zip:

Phone #1:	Phone #2:

Email:

I have a living will. ☐ Yes ☐ No Keep a copy in ***My Companion Guidebook*** and give one to your healthcare team.

I have a durable power of attorney (healthcare proxy). ☐ Yes ☐ No

If yes, list Name:	Relationship:

Phone:

My Healthcare Team (You may not have all of these on your healthcare team.)

Medical Oncologist:

Phone:	Fax:		
Address:	City:	State:	Zip:
Email:	Portal:		

Radiation Oncologist:

Phone:	Fax:		
Address:	City:	State:	Zip:
Email:	Portal:		

Oncology Nurse:

Phone:	Fax:		
Address:	City:	State:	Zip:
Email:	Portal:		

Surgeon:

Phone:	Fax:		
Address:	City:	State:	Zip:
Email:	Portal:		

My Healthcare Contacts continued on next page

Primary Care Provider (Physician Assistant/Nurse Practitioner):

Phone:			Fax:
Address:	City:	State:	Zip:
Email:	Portal:		

Pharmacy:

Phone:			Fax:
Address:	City:	State:	Zip:
Email:	Portal:		

Social Worker:

Phone:			Fax:
Address:	City:	State:	Zip:
Email:	Portal:		

Navigator/Promotora:

Phone:			Fax:
Address:	City:	State:	Zip:
Email:	Portal:		

Hospital:

Phone:			Fax:
Address:	City:	State:	Zip:
Email:	Portal:		

Medical Lab:

Phone:			Fax:
Address:	City:	State:	Zip:
Email:	Portal:		

Other:

Phone:			Fax:
Address:	City:	State:	Zip:
Email:	Portal:		

Other:

Phone:			Fax:
Address:	City:	State:	Zip:
Email:	Portal:		

MY PERSONAL CONTACTS

Caregivers, Family Members, Friends, Neighbors, Support Groups, Co-Workers, Child Care, Clergy

Name:		Phone #1:
Phone #2:	Email:	
Relationship/Notes:		

Name:		Phone #1:
Phone #2	Email:	
Relationship/Notes:		

Name:		Phone #1:
Phone #2:	Email:	
Relationship/Notes:		

Name:		Phone #1:
Phone #2:	Email:	
Relationship/Notes:		

Name:		Phone #1:
Phone #2:	Email:	
Relationship/Notes:		

Name:		Phone #1:
Phone #2:	Email:	
Relationship/Notes:		

Name:		Phone #1:
Phone #2:	Email:	
Relationship/Notes:		

Name:		Phone #1:
Phone #2:	Email:	
Relationship/Notes:		

MY INSURANCE AND BENEFIT CONTACTS

Primary Insurer: ☐ Self ☐ Spouse

Address: City: State: Zip:

Group #: Policy #: Plan #:

Representative: Phone:

Copay: $ Deductible: $

Email:

Secondary Insurer: ☐ Self ☐ Spouse

Address: City: State: Zip:

Group #: Policy #: Plan #:

Representative: Phone:

Copay: $ Deductible: $

Email:

Notes

MY CURRENT MEDICATIONS (MEDICINES)

Record prescriptions, over-the-counter medicines, vitamins, herbs, and supplements you currently take.

Name:

Pharmacy/Location: Phone:

Rx Allergies/Reactions:

DRUG NAME	DATE STARTED	FREQUENCY AND DOSAGE	REASON TAKING	PRESCRIBED BY

Reactions and Side Effects
(Frequency/Duration/Severity)

DRUG NAME	DATE STARTED	FREQUENCY AND DOSAGE	REASON TAKING	PRESCRIBED BY

Reactions and Side Effects
(Frequency/Duration/Severity)

DRUG NAME	DATE STARTED	FREQUENCY AND DOSAGE	REASON TAKING	PRESCRIBED BY

Reactions and Side Effects
(Frequency/Duration/Severity)

DRUG NAME	DATE STARTED	FREQUENCY AND DOSAGE	REASON TAKING	PRESCRIBED BY

Reactions and Side Effects
(Frequency/Duration/Severity)

DRUG NAME	DATE STARTED	FREQUENCY AND DOSAGE	REASON TAKING	PRESCRIBED BY

Reactions and Side Effects
(Frequency/Duration/Severity)

DRUG NAME	DATE STARTED	FREQUENCY AND DOSAGE	REASON TAKING	PRESCRIBED BY

Reactions and Side Effects
(Frequency/Duration/Severity)

MY PAST MEDICATIONS (MEDICINES)

Record prescriptions, over-the-counter medicines, vitamins, herbs, and supplements you no longer take.

DRUG NAME	DATE STARTED/STOPPED	FREQUENCY AND DOSAGE	REASON TAKING	PRESCRIBED BY

Reactions and Side Effects
(Frequency/Duration/Severity)

DRUG NAME	DATE STARTED/STOPPED	FREQUENCY AND DOSAGE	REASON TAKING	PRESCRIBED BY

Reactions and Side Effects
(Frequency/Duration/Severity)

DRUG NAME	DATE STARTED/STOPPED	FREQUENCY AND DOSAGE	REASON TAKING	PRESCRIBED BY

Reactions and Side Effects
(Frequency/Duration/Severity)

DRUG NAME	DATE STARTED/STOPPED	FREQUENCY AND DOSAGE	REASON TAKING	PRESCRIBED BY

Reactions and Side Effects
(Frequency/Duration/Severity)

DRUG NAME	DATE STARTED/STOPPED	FREQUENCY AND DOSAGE	REASON TAKING	PRESCRIBED BY

Reactions and Side Effects
(Frequency/Duration/Severity)

DRUG NAME	DATE STARTED/STOPPED	FREQUENCY AND DOSAGE	REASON TAKING	PRESCRIBED BY

Reactions and Side Effects
(Frequency/Duration/Severity)

DRUG NAME	DATE STARTED/STOPPED	FREQUENCY AND DOSAGE	REASON TAKING	PRESCRIBED BY

Reactions and Side Effects
(Frequency/Duration/Severity)