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My Appointment Notes			
Doctor:		**Date of Visit:**	
Questions to Ask the Doctor:			
Notes from the visit:			
Things to be done after this visit:			
Tests to schedule			
Prescriptions to fill			
:			

Date of next appointment: _____

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My History

My Cancer Diagnosis

Date of Surgery or Biopsy	
Doctor	
Place Procedure Was Performed	
Surgery Performed	
Results of the Surgery	
Primary Cancer Type	
Type of Tumor (Histological Type)	
Stage of Disease	
Any Problems Since the Surgery	
Other İnformation	
Treatments	

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My History

My İnsurance Coverage:

Primary İnsurance	Name of İnsured
	Company Name
	Address
	City, State, Zip
	Phone
	Fax
	Policy Number
	Social Security # of İnsured
Secondary İnsurance	Name of İnsured
	Company Name
	Address
	City, State, Zip
	Phone
	Fax
	Policy Number
	Social Security # of İnsured

My Medical Profile

Surgeries:			
Type of Surgery	Date	Hospital	Reason for Surgery

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My History

My Medical Profile

Medical Conditions: (For example: high blood pressure, heart trouble, diabetes, depression, etc.)

Condition	Year Diagnosed	How is it treated?

Allergies: (For example: medications, food and/or other substances)

Allergy	Allergic Reaction: (What symptoms develop?)

Medications I Take: Information the doctor will want to know for each medication:

Why are you taking it? How Long have you been taking it?

What is the dosage? How many times a day do you take it?

Medication	Dose	Number of Times Taken Per Day	Date Started	Prescribed By

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My History

My Medical Profile

Other Medications I Take: *Remember to include on your list any over the counter (OTC) medicine you take (vitamins, herbs, painrelievers, supplements, etc)*

Information the doctor will want to know for each medication:

Why are you taking it? How Long have you been taking it?

What is the dosage? How many times a day do you take it?

Medication	Dose	Number of Times Taken Per Day	Date Started

Other Information to share with my health-care team:

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My Health Care Team
My Oncologist/Hematologist:
Name
Address
City/State/Zip
Telephone
Fax
Email
Plan of Care:
Notes:
:

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My Health Care Team
Other Doctors İ See: (For example: Cardiologist, Allergist, etc.)
Name
Address
City/State/Zip
Telephone
Fax
Email
Notes:
:

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My Health Care Team
Other Members of My Health Care Team: (For example: Nurses, Social Workers, Physical Therapists, etc.)
Name
Address
City/State/Zip
Telephone
Fax
Email

Name
Address
City/State/Zip
Telephone
Fax
Email

Name
Address
City/State/Zip
Telephone
Fax
Email

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Pain Tracker

Date & Time	Was Pain Episode Related to Activity?	Level of Pain at its Worst (0 =No Pain and 10 =Worst Possible Pain)	Location of Pain	
	Yes or No		Front 	Back 

Pain Description			Medication or Other Therapy	When did you feel improvement after treatment	Level of Pain at its Worst (0 =No Pain and 10 =Worst Possible Pain)
Aching	İntense	Stabbing			
Burning	Numb	Stinging			
Cramping	Radiating	Tender			
Deep	Sharp	Throbbing			
Dull	Shooting	Tingling			
Electric	Other_____				

Date & Time	Was Pain Episode Related to Activity?	Level of Pain at its Worst (0 =No Pain and 10 =Worst Possible Pain)	Location of Pain	
	Yes or No		Front 	Back 

Pain Description			Medication or Other Therapy	When did you feel improvement after treatment	Level of Pain at its Worst (0 =No Pain and 10 =Worst Possible Pain)
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Cramping	Radiating	Tender			
Deep	Sharp	Throbbing			
Dull	Shooting	Tingling			
Electric	Other_____				

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My Health Care Team
My Primary Care Doctor:
Name
Address
City/State/Zip
Telephone
Fax
Email
Notes:
:

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My Health Care Team
My Radiation Oncologist:
Name
Address
City/State/Zip
Telephone
Fax
Email
Plan of Care:
Notes:
:

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My Scheduled Tests

Test Details

Name of Test (CT Scan, MRI , X-ray, etc.)	
Reason for test:	
Where the test will be done:	
Who will perform the test?	
Any special preparation for the test? Can I eat & drink before the test? Should I take my regular medications? etc.	
How long will the test take?	
Will I be able to take myself home or do I need someone to drive for me?	
How long will it take to get the results of this test?	
How will I get the results?	
Other Notes:	

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My Health Care Team
My Surgeon:
Name
Address
City/State/Zip
Telephone
Fax
Email
Plan of Care:
Notes:
:

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Symptom Tracker

Track your symptoms and rate them on a scale of 1 to 5. 1 affecting you the least and 5 affecting you the most. For fevers and weight, write in the exact number below.

Date ↓ / Symptoms	Weight	Nausea									
4/24	165	3									
4/24	163	5									