

My Appointment Notes			
Doctor:		Date of Visit:	
Question	s to Ask the Doctor:		
Notes fr	om the visit:		
	be done after this visit:		
Tests to s	chedule		
Prescripti	ons to fill		
:			

Date of next appointment:



	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 Information	
Treatments	



My	History	
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İnsurance Coverage:
Name of Insured
Company Name
Address
City, State, Zip
Phone
Fax
Policy Number
Social Security # of İnsured
Name of İnsured
Company Name
Address
City, State, Zip
Phone
Fax
Policy Number
Social Security # of Insured
Medical Profile

Surgeries:			
Type of Surgery	Date	Hospital	Reason for Surgery



#### **My History**

How is it treated?

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

Year Diagnosed

#### **My Medical Profile**

Condition

Allorgios: (For ovam	nlo: r	modications foo	d and/or other substa	uncos)		
-	ipie. i	nedications, food and/or other substances)  Allergic Reaction: (What symptoms develop?)				
Allergy		Allergic Reactio	n: (what symptoms a	evelop ri		
<b>Medications İ Take</b> Why are you to What is the do	aking	it?	or will want to know f Ho	or each medication: How Long have you ow many times a day		
Medication	Dose	9	Number of Times Taken Per Day	Date Started	Prescribed By	



	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? 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 sho	re with my health-care	team:			



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



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



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



#### Havasu Community Health Foundation

#### havasuhealthfoundation.org

Pain Tracker							
Date & Time	Was Pain Episode Related to Activity?	(0	f Pain at its Worst =No Pain and orst Possible Pain)		Location of Pain		
	Yes or No					Front Back	
Pain Description		Medication or Other Therapy		hen did you feel provement after treatment	Level of Pain at its Worst (0 =No Pain and 10 =Worst Possible Pain)		
Aching Burning Cramping Deep Dull Electric	Numb Radiating	Stabbing Stinging Tender nrobbing Tingling	.,				
Date & Time	Was Pain Episode Related to Activity?	(0	f Pain at its Worst =No Pain and orst Possible Pain)		Location of Pain		
	Yes or No				F	Front Back	
Pain Description		Medication or Other Therapy		hen did you feel provement after treatment	Level of Pain at its Worst (0 =No Pain and 10 =Worst Possible Pain)		
Aching Burning Cramping Deep Dull Electric	Numb Radiating	Stabbing Stinging Tender hrobbing Tingling					



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



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



#### **My Scheduled Tests**

Test Details	
Name of Test (CT Scan, MRİ , 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:	



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



#### **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					