



Havasu Community Health Foundation
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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 Information

Treatments



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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 I 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



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	Intense	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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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 Health Care Team

My Surgeon:

Name

Address

City/State/Zip

Telephone

Fax

Email

Plan of Care:**Notes:**

:

