



I Have Cancer

■ Allergies

■ Other Medical Conditions

■ Notes

Cancer.Net

Doctor-Approved Patient Information from ASCO®

ASCO

AMERICAN SOCIETY OF CLINICAL ONCOLOGY

FOLD HERE FIRST

■ Current Treatments

NAME/DOSAGE/FREQUENCY

(Include over-the-counter medications)

■ Current Medications

■ Personal Information

NAME

PHONE

ADDRESS

■ Vitals

AGE: _____ SEX: _____ BLOOD TYPE: _____

HEIGHT: _____ WEIGHT: _____

■ Emergency Contact

NAME

PHONE

Cancer.Net

Doctor-Approved Patient Information from ASCO®

ASCO

AMERICAN SOCIETY OF CLINICAL ONCOLOGY

PHONE

NAME

PHARMACIST/PHARMACY

PHONE

NAME

HOSPITAL

PHONE

NAME

FAMILY DOCTOR

PHONE

NAME

ONCOLOGIST

■ Doctor Contacts

FOLD HERE SECOND