**MY HISTORY**

**MY INFORMATION**

|  |  |
| --- | --- |
| **Name** |  |
| **Date of Birth** |  |
| **Address** |  |
| **City, State, Zip** |  |
| **Home Phone** |  |
| **Work Phone** |  |
| **Cell Phone** |  |
| **Fax** |  |
| **E-mail** |  |

**MY FAMILY CONTACTS**

**IN THE EVENT OF AN EMERGENCY, THE FIRST PERSON TO CONTACT IS:**

|  |  |
| --- | --- |
| **Name** |  |
| **Relationship** |  |
| **Address** |  |
| **City, State, Zip** |  |
| **Home Phone** |  |
| **Work Phone** |  |
| **Cell Phone** |  |
| **Fax** |  |
| **E-mail** |  |

**THE SECOND PERSON TO CONTACT IS:**

|  |  |
| --- | --- |
| **Name** |  |
| **Relationship** |  |
| **Address** |  |
| **City, State, Zip** |  |
| **Home Phone** |  |
| **Work Phone** |  |
| **Cell Phone** |  |
| **Fax** |  |
| **E-mail** |  |

**MY HISTORY**

**MY INSURANCE COVERAGE**

(Remember to bring your insurance cards every time you see a new doctor.)

**PRIMARY:**

|  |  |
| --- | --- |
| **Name of Insured** |  |
| **Company Name** |  |
| **Address** |  |
| **City, State, Zip** |  |
| **Telephone** |  |
| **Fax** |  |
| **Policy Numbers** |  |

**SECONDARY:**

|  |  |
| --- | --- |
| **Name of Insured** |  |
| **Company Name** |  |
| **Address** |  |
| **City, State, Zip** |  |
| **Telephone** |  |
| **Fax** |  |
| **Policy Numbers** |  |

**MY MEDICAL PROFILE**

**SURGERIES:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Surgery** | **Date** | **Hospital** | **Reason for Surgery** |
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**MY HISTORY**

**MY MEDICAL PROFILE (CONTINUED**)

**MEDICAL CONDITIONS:** (For example: high blood pressure, heart trouble, diabetes, depression, breathing problems, other)

|  |  |  |
| --- | --- | --- |
| **Condition** | **Year Diagnosed** | **How Is it Treated** |
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**ALLERGIES:** (For example: medications, food, and/or other substances)

|  |  |
| --- | --- |
| **Allergy** | **Allergic Reaction (What symptoms develop?)** |
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**MEDICATION 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 the medication? (If you are not sure, bring the medication with you.)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Dose** | **Number of Times Taken Per Day** | **Date Started** | **Prescribed By** |
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**MY HISTORY**

**MY MEDICAL PROFILE (CONTINUED)**

**OTHER MEDICATION I TAKE:**

Remember to include on your list any over-the-counter (OTC) medicine you take (vitamins, herbs, pain relievers, supplements, etc.).

|  |  |  |  |
| --- | --- | --- | --- |
| **Other Medication** | **Dose** | **Number of Times Taken Per Day** | **Date Started** |
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**OTHER INFORMATION TO SHARE WITH MY HEALTH-CARE TEAM:**

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**MY HISTORY**

**MY CANCER DIAGNOSIS**

|  |  |
| --- | --- |
| **Date of Surgery or Biopsy** |  |
| **Doctor** |  |
| **Place Procedure Was Performed** |  |
| **Surgery That Was Performed** |  |
| **Results of My Surgery** |  |
| **Primary Cancer Type** |  |
| **Type of Tumor (Histological Type)** |  |
| **Stage of Disease** |  |
| **Any Problems Since My Surgery** |  |

**OTHER INFORMATION:**

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**TREATMENTS:**

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