My Personal Medical Information

Date:_____

Name: Date of Birth:

(Keep copies of front and back sides of your insurance cards with you to be left with office for billing.)

Primary Support Person (Caregiver)

Name: Relationship:

Phones: Home: Cell: Work:

Record of Diagnostic Testing

Type	Date	Outcome/Location

Past Cancer History (Make more copies if needed.)

Type of Cancer: Date diagnosed:

Doctor's name: Facility:

Address: Phone: FAX:

Past Cancer Treatment **Details/Side Effects During & After Treatment**

- ☐ Chemotherapy _____
- ☐ Surgery _____
- ☐ Radiation _____
- ☐ Hormone _____
- ☐ Immunotherapy _____
- ☐ Other (transplant) _____

Current Diagnosis

_____ Diagnosis Date: _____

Current/Past Health Conditions Please check all that apply.

Current	Past		Current	Past		Current	Past	
☐	☐	Allergies	☐	☐	Gynecological problems	☐	☐	Seizures/epilepsy
☐	☐	Arthritis	☐	☐	Heart problems	☐	☐	Skin disorders
☐	☐	Asthma	☐	☐	Hepatitis	☐	☐	Shingles
☐	☐	Blood disorder	☐	☐	High blood pressure	☐	☐	Stroke
☐	☐	Circulation problems	☐	☐	HIV/AIDS	☐	☐	Thyroid problems
☐	☐	Depression/anxiety	☐	☐	Kidney/urine problems	☐	☐	Tuberculosis
☐	☐	Diabetes	☐	☐	Liver problems	☐	☐	Ulcers
☐	☐	Frequent infections	☐	☐	Lung problems	☐	☐	Other _____
☐	☐	Gastrointestinal problems	☐	☐	Prostate problems			

Please provide detailed information

_____

_____

_____

Please list past surgeries. (Make more copies if needed.)

Type of Surgery	Date	Outcome, Surgeon, Location

Family history Please note any of your relatives who have had a chronic illness (for example, cancer, heart disease, diabetes).

☐ Biological mother	☐ Maternal grandmother	☐ Maternal grandfather
☐ Biological father	☐ Paternal grandmother	☐ Paternal grandfather
☐ Sibling	☐ Sibling	☐ Sibling
☐ Aunt	☐ Uncle	☐ Other _____

Please provide details in the space provided.

_____

_____

_____

Do you have a living will or an advance directive? ☐ Yes ☐ No

(Keep a copy with you and add to your USB Wristband so your wishes will be honored.)

Do you have a healthcare proxy? ☐ Yes ☐ No

If yes, list Name: _____ Phone: _____