

# 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	
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Gynecological problems	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Skin disorders
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Shingles
<input type="checkbox"/>	<input type="checkbox"/>	Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Circulation problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems
<input type="checkbox"/>	<input type="checkbox"/>	Depression/anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/urine problems	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Liver problems	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Frequent infections	<input type="checkbox"/>	<input type="checkbox"/>	Lung problems	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal problems	<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems			

**Please provide detailed information**

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**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).

<input type="checkbox"/> Biological mother	<input type="checkbox"/> Maternal grandmother	<input type="checkbox"/> Maternal grandfather
<input type="checkbox"/> Biological father	<input type="checkbox"/> Paternal grandmother	<input type="checkbox"/> Paternal grandfather
<input type="checkbox"/> Sibling	<input type="checkbox"/> Sibling	<input type="checkbox"/> Sibling
<input type="checkbox"/> Aunt	<input type="checkbox"/> Uncle	<input type="checkbox"/> Other _____

Please provide details in the space provided.

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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: \_\_\_\_\_