Organize Your Medical History

Rare Cancer Medical History Documents and Reports

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Keeping Your Own Records

It's very important to keep you own records. You will be seeing different health care providers such as surgeons, radiologists, oncologists, and other specialists. Providing them with details of your medial history will help them create the best medical treatments and care for your type of cancer. You will also want to get copies of your tests such as MRI'S PET scans and blood tests. It is also a good idea to keep a record of the medications you have taken. The more information you can provide may prove helpful with making the best decisions for your health care and treatments. We have provided work sheets that you can make copies of and share with your health care providers.

Follow-up and Tests

Surgery ______________________________

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Oncology ______________________________

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Radiation ______________________________

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Stem and Cell Bone Marrow ______________________________

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MRI ____

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PET Scan ____

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X-ray ____

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Medication Records

Name of Medication ____

Dosage ____

Date Started – Ended ____

Complications ____

Name of Medication ____

Dosage ____

Date Started – Ended ____

Complications ____

Name of Medication ____

Dosage ____

Date Started – Ended ____

Complications ____

Name of Medication ____

Dosage ____

Date Started – Ended ____

Complications ____

Surgery

Telephone number of institution: ______________________________

Medical record number: ______________________________

Surgeon's name: ______________________________

Surgeon's telephone number: ______________________________

Nurse practitioner's name: ______________________________

Date of surgery: ______________________________

Type of surgery: ______________________________

Name and address of institution where you had surgery: ______________________________

Medications after surgery: ______________________________

Any major complications: ______________________________

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Radiation

Telephone number of institution: ______________________________

Medical record number: ______________________________

Name of physician who supervised radiation therapy: ______________________________

Physician's telephone number: ______________________________

Nurse or nurse practitioner's name: ______________________________

Name and address of institution where radiation was given: ______________________________

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1. Dates radiation given: ______________________________

Type of machine or technology Used: ______________________________
(e.g., linear accelerator, Radioactive seeds, radiation Ablation, etc) ______________________________

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Area treated (include any areas shielded): ______________________________

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Amount per session: ______________________________

Total number of treatments: ______________________________

Side effects: ______________________________

Medications given: ____

Chemotherapy

Telephone number of institution: ____________________

Medical record number: ____________________

Oncologist's name: ____________________

Oncologist's telephone number: ____________________

Nurse or nurse practitioner's name: ____________________

Name and address of institution where chemotherapy was given: ____________________

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Type of central line (if any): ____________________

Complications with central line (if any): ____________________

Name of treatment protocol or clinical trial: ____________________

Side Effects: ____________________

1. Name of medication: ____________________

Dose per administration: ____________________

Number of doses: ____________________

Cumulative dose: ____________________

How given (pills, IV through a Peripheral vein, IV through a Central line, introthecal, etc): ____________________

Blood count: ____

Chemotherapy

2. Name of medication: ______________________________

Dose per administration: ______________________________

Number of doses: ______________________________

Cumulative dose: ______________________________

How given: ______________________________

3. Name of medication: ______________________________

Dose per administration: ______________________________

Number of doses: ______________________________

Cumulative dose: ______________________________

How given: ______________________________

4. Name of medication: ______________________________

Dose per administration: ______________________________

Number of doses: ______________________________

Cumulative dose: ______________________________

How given: ______________________________

Stem Cell or Bone Marrow Transplant

Telephone number of institution: ______________________________

Medical record number: ______________________________

Name of physician who supervised transplant: ______________________________

Physician's telephone number: ______________________________

Nurse or nurse practitioner's name: ______________________________

Any major complications from transplant: ______________________________

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Date(s) of transplant: ______________________________

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Type(s) of transplant: ______________________________

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Name and address of institution where transplant was performed: ______________________________

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Stem Cell or Bone Marrow Transplant
Chemotherapy prior to transplant

1. Name of medication: ______________________________

   Total doses: ______________________________

   How given (pills, Peripheral IV, central line, introthecal, etc): ______________________________

2. Name of medication: ______________________________

   Total doses: ______________________________

   How given: ______________________________

3. Name of medication: ______________________________

   Total doses: ______________________________

   How given: ______________________________

4. Name of medication: ______________________________

   Total doses: ______________________________

   How given: ______________________________

5. Name of medication: ______________________________

   Total doses: ______________________________

   How given: ______________________________

Blood Product Transfusions

Number, types, and dates of transfusions:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________

Date and results of Hepatitis C testing (necessary if transfused Before July 1992): ______________________________

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Date and results of HIV testing: ______________________________

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