

*Cancer Survivor's  
Treatment Record*

# Taking Care of Yourself for Life

This booklet helps you keep track of your medical history, with:

- A summary of your cancer treatment.
- Guidelines for health monitoring that may reduce your chances of medical problems in the future.
- Suggestions for additional resources for information and assistance.

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Name

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Medical Record Number

## GENERAL HEALTH HISTORY INFORMATION

1. Name of disease you had: \_\_\_\_\_  
\_\_\_\_\_

2. Date of diagnosis:  
Month/Year \_\_\_\_\_

3. Date all treatment was completed:  
Month/Year \_\_\_\_\_

4. Date of any relapses: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Place of treatment:  
Institution \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone number \_\_\_\_\_

6. The doctor and/or nurse practitioner most responsible for your care:  
Name(s) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone number \_\_\_\_\_



**Place of Treatment:**

Institution \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone number \_\_\_\_\_

Your radiation therapy was supervised by Dr. \_\_\_\_\_

\_\_\_\_\_

**BONE MARROW TRANSPLANTATION**

**Date and Types of BMT(s):**

Month/Year/Type \_\_\_\_\_

Month/Year/Type \_\_\_\_\_

**BMT CHEMOTHERAPY**

DRUG NAME	TOTAL DOSE	HOW GIVEN: IV, BY MOUTH, INTRATHECALLY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**BMT RADIATION THERAPY**

DATE	AREA TREATED	TOTAL DOSE
_____	_____	_____
_____	_____	_____

**Place of Treatment:**

Institution \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone number \_\_\_\_\_

Doctor responsible for your BMT was Dr. \_\_\_\_\_

\_\_\_\_\_

## DISEASE/TREATMENT COMPLICATIONS

These problems were complications you had during treatment (other than fever and low blood counts):

DATE	COMPLICATION
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

## YOUR MEDICAL FOLLOW-UP

These are special instructions for monitoring your health in the future, based on the treatment you received:

TREATMENT	ORGANS AT RISK	MEDICAL TESTS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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_____	_____	_____
_____	_____	_____
_____	_____	_____

## THINGS TO DO FOR YOUR HEALTH

You have an important responsibility for your health. Today more people are cured of cancer than ever before. You can help yourself and anyone who gives you medical care by:

- Knowing about your disease and its treatment.
- Having checkups once a year, with a physical examination, blood count, urinalysis, and recommended tests.
- Staying in touch with the medical center or clinic where you were originally treated for cancer, at least once a year.
- Learning the 10 steps to a healthier life and a reduced adult cancer risk suggested by the American Cancer Society.
- Making use of available resources for information and support.
- Keeping a copy of all your test results (MRI, CT scan, etc.) so they are available if needed for comparison.

## RESOURCES

### **American Cancer Society**

1599 Clifton Rd. N.E.  
Atlanta, Georgia 30329  
(800) ACS-2345  
<http://www.cancer.org>

### **The Association of Cancer Online Resources, Inc. (ACOR)**

Offers a wide range of electronic discussion groups that provide information and support to patients, caregivers, and families.  
<http://www.acor.org>

### **Canadian Cancer Society**

565 W. 10th Ave.  
Vancouver, BC V5Z 4J4  
(800) 663-2524  
<http://www.bc.cancer.ca>

### **Cancervive**

6500 Wilshire Blvd., Suite 500  
Los Angeles, CA 90048  
(310) 203-9232

### **Candlelighters Childhood Cancer Foundation**

3910 Warner St.  
Kensington, MD 20895  
(800) 366-2223  
<http://www.candlelighters.org>

### **National Cancer Institute**

Office of Cancer Information, Communication, and Education  
Building 31, Room 10A 10  
31 Center Dr. MSC 2580  
Bethesda, MD 20892  
(800) 4-CANCER  
<http://www.nci.nih.gov>

### **The National Coalition for Cancer Survivorship**

1010 Wayne Ave., Suite 505  
Silver Spring, MD 20910  
(301) 650-9127  
<http://www.cansearch.org>

## OTHER RESOURCES IN YOUR AREA

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### THIS SUMMARY OF YOUR DISEASE AND TREATMENT WAS PREPARED BY:

Name \_\_\_\_\_

Date \_\_\_\_\_

Keep this copy for your records. Make copies as needed for your doctors or nurses. Contact the following person where you were treated whenever your medical condition or address changes, or if you have questions about your follow-up.

## Patient-Centered Guides

[www.patientcenters.com](http://www.patientcenters.com)

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[patientguides@oreilly.com](mailto:patientguides@oreilly.com)

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