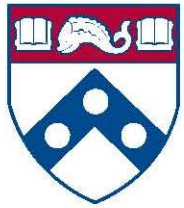


**Abramson Cancer Center**



**Penn Medicine**

# **Treatment Organizer**



## Medical History

Name	Date of Birth	Sex
Phone (home)	(cell)	(work)
Emergency Contact	Relationship	Phone
Primary Care Physician	Phone	
Primary Insurance	Phone	
Insured Name	Group #	Policy #
Secondary Insurance	Phone #	
Insured Name	Group #	Policy #

### Caregiver (primary support person)

Name	Relationship
Phone (home)	(cell) (work)
Do you have an advance directive or living will? <input type="checkbox"/> Yes <input type="checkbox"/> No (If you have an advance directive, keep a copy with you so your wishes may be honored)	
Do you have a healthcare proxy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, list Name	Phone #

### Past Cancer History

Have you ever been diagnosed with cancer in the past? If you have, list details of the cancer treatment you received

Type of Cancer
Date Diagnosed
By Whom
Treatment
<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Surgery
<input type="checkbox"/> Radiation
<input type="checkbox"/> Hormone

## Current Diagnosis

Type of Cancer \_\_\_\_\_

Date \_\_\_\_\_

## Medical History Please check all that apply to you

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seizures/epilepsy
<input type="checkbox"/> Asthma	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Skin Disorder
<input type="checkbox"/> Blood/bleeding disorders	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Shingles
<input type="checkbox"/> Depression/anxiety	<input type="checkbox"/> Kidney/bladder problems	<input type="checkbox"/> Stroke
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Gastrointestinal Problems	<input type="checkbox"/> Lung problems	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Gynecological Problems	<input type="checkbox"/> Prostate problems	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Heart Disease		

<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Coughing blood	<input type="checkbox"/> Involuntary weight loss
<input type="checkbox"/> Ankle/leg swelling	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Nose or gum bleeding
<input type="checkbox"/> Balance problems	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Numbness
<input type="checkbox"/> Black/blood stools	<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Palpitations
<input type="checkbox"/> Blood in the Uterine	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Problems urinating
<input type="checkbox"/> Bone pain	<input type="checkbox"/> Fevers, chills, night sweats	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Fingers turn blue in the cold	<input type="checkbox"/> Substance abuse
<input type="checkbox"/> Change in Vision	<input type="checkbox"/> Frequent Nausea/Vomiting	<input type="checkbox"/> Tinnitus (ringing in ears)
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Headaches	<input type="checkbox"/> Vomiting blood
<input type="checkbox"/> Cough	<input type="checkbox"/> Hoarse voice	<input type="checkbox"/> Weakness

Smoking packs per day \_\_\_\_\_

Alcohol use drinks per day \_\_\_\_\_

### Menstrual history

Age of onset \_\_\_\_\_

Have you ever taken birth control pills or estrogen replacement?  Yes  No

Date of last period \_\_\_\_\_

Pregnancies #\_\_ Abortions/Miscarriages#\_\_

Post-menopausal bleeding  Yes  No

Children born alive #

Date of last Pap test \_\_\_\_\_ Results  Pos  Neg Your age when last child was born \_\_\_\_\_

**Surgical history** (please include all cancer-related procedures)

Type of Surgery	Date	Type of Surgery	Date

**Current Medications\*** (Note: It may be easier to bring your current medication bottles with you)

Name of Medication	Date	How often did you take in one day?	When did you start taking it?

**Medications you have taken in the past\***

Name of Medication	Dose	How often did you take in one day?	When did you start taking it?	Date Stopped

\* Include any prescription medications, over-the-counter medications (for example, aspirin, vitamins), herbal medicine or alternative therapy

# Allergies

## Reactions

Penicillin \_\_\_\_\_

Sulfa \_\_\_\_\_

Morphine \_\_\_\_\_

Latex \_\_\_\_\_

## Reactions

CT Dye \_\_\_\_\_

Aspirin \_\_\_\_\_

Tape \_\_\_\_\_

## Other Allergies

## Reaction

Other Allergies	Reaction

## Family History

Have any of your relatives had a chronic illness (for example, cancer, heart disease, diabetes)?

Relative	Specify Chronic Illness(es)	Living	Deceased
Biological mother		<input type="checkbox"/>	<input type="checkbox"/>
Biological father		<input type="checkbox"/>	<input type="checkbox"/>
Maternal grandmother		<input type="checkbox"/>	<input type="checkbox"/>
Maternal grandfather		<input type="checkbox"/>	<input type="checkbox"/>
Paternal grandmother		<input type="checkbox"/>	<input type="checkbox"/>
Paternal grandfather		<input type="checkbox"/>	<input type="checkbox"/>
Siblings		<input type="checkbox"/>	<input type="checkbox"/>
Aunt(s)		<input type="checkbox"/>	<input type="checkbox"/>
Uncle(s)		<input type="checkbox"/>	<input type="checkbox"/>

## Questions to Ask Your Doctor or Nurse

Questions you may want to ask about your treatment plan

What is the primary site or type of cancer?

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What is the stage?

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Has the primary tumor spread cancer cells to other organs? (metastasized)

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What does the treatment plan include?

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Radiation  Yes  No

Surgery  Yes  No

Chemotherapy  Yes  No

Hormone (endocrine) therapy  Yes  No

What are the risks with this treatment?

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When will my treatment start?

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---

Will my health insurance cover treatment?

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Do you have any information I can read, or websites to visit?

---

Can you recommend a patient with a similar experience I can talk to?

---

List other questions you may have

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## Other Health Issues and Appointments

Use this space to record healthcare appointments for issues other than your regularly scheduled cancer treatments

**BEFORE FILLING OUT THIS PAGE, YOU MAY WANT TO MAKE ADDITIONAL COPIES**

**Date**

---

Diagnosis/illness/presenting problem

---

Healthcare provider/specialist

---

Nurse

---

Treatment/recommendations/decisions

---

Follow-up appointments

---

**Date**

---

Diagnosis/illness/presenting problem

---

Healthcare provider/specialist

---

Nurse

---

Treatment/recommendations/decisions

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Follow-up appointments

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Follow-up appointments

---

**Date**

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Diagnosis/illness/presenting problem

---

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Healthcare provider/specialist

---

Nurse

---

Treatment/recommendations/decisions

---

---

Follow-up appointments

---

<u>SUNDAY</u>	<u>MONDAY</u>	<u>TUESDAY</u>	<u>WEDNESDAY</u>	<u>THURSDAY</u>	<u>FRIDAY</u>	<u>SATURDAY</u>

**800.789.PENN PennMedicine.org/abramson**



<u>SUNDAY</u>	<u>MONDAY</u>	<u>TUESDAY</u>	<u>WEDNESDAY</u>	<u>THURSDAY</u>	<u>FRIDAY</u>	<u>SATURDAY</u>

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# Treatment and Side Effects Log

Work with your treatment team to fill in the chart below

## Chemotherapy Treatment\*

	<b>How given</b>	<b>Treatment schedule</b>
<i>Example: Chemotherapy drug #1</i>	<i>Orally</i>	<i>Tablets per day days 1-14 no tablets days 15-21 (1 cycle=21 days)</i>
<i>Example: Chemotherapy drug #2</i>	<i>IV</i>	<i>Administered every 3 weeks (1 cycle = 3 weeks)</i>

\* Administration of chemotherapy drugs is often repeated. This can be anywhere from 1 to 4 weeks. This is referred to as a cycle. Your oncology treatment team will be advise you as to the length of the specific chemotherapy you will receive.

Special Instructions:

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Be sure to tell your treatment team what, if any, medications, over-the-counter drugs, vitamins or herbal supplements you are taking. This is important because even the most common drugs can affect your chemotherapy. For instance, antioxidants (such as vitamin C) can reduce the effectiveness of some chemotherapy drugs.

**Work with your treatment team to fill in the chart below**

**Radiation Treatment**

<b>Body</b>	<b>Start Date</b>	<b>Stop Date</b>	<b>Treatment Schedule</b>
<i>Example: Left Breast</i>	<i>4/1/08</i>	<i>4/15/08</i>	<i>Monday - Friday</i>

Special Instructions:

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Work with your treatment team to fill in the chart below

Hormone Treatment

Body	Start Date	Treatment Schedule
<i>Example: Hormone Drug</i>	<i>Orally</i>	<i>1x per day</i>

Special Instructions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Work with your treatment team to fill in the chart below**

Possible side effect	Report	Treat/prevent (prescribed medication)	Treat/prevent (what can I do)
<i>Example: Nausea, Vomiting</i>	<i>Any</i>	<i>Drug #1</i>	<i>Eat small meals, often, slowly – rest one hour – skip fatty foods</i>

Someone commonly reported side effects are: bleeding; bruising; confusion; constipation; diarrhea; fatigue; hair loss; numbness, tingling and redness of the hands and feet; infection; loss of appetite; metallic taste; mouth sores; nausea and vomiting; tender or bleeding gums; and throat problems.

I should call my treatment team immediately if I experience:

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## Tests: Imaging and Lab

Work with your treatment team to fill in the log below

### Medical Imaging Log

<i>Type of Test</i>	<i>Where test performed</i>	<i>Date</i>	<i>Notes</i>
<i>Example: Bone Scan</i>	<i>Medical Center</i>	<i>2/15/08</i>	<i>Results discussed with doctor</i>



## Health Insurance

**It is important to keep track of your interactions with your insurance company. This may be important if there is a discrepancy between you and your insurance company sometime.**

It's time to get out your policy and read it – or, if someone has offered to help, have them read it. If you don't understand something, call your insurance company and tell them you need someone to translate your benefits to you. If you can, have a partner or friend listen in and takes notes.

If you need to get your healthcare providers to write a “referral” for other treatments or tests you need, be sure to check that it has been done. It is a good idea to check in regularly with your primary care physician's staff person who deals with referrals and authorizations.

## Keep the names of your insurance carriers and your plan ID numbers here

Primary insurance provider \_\_\_\_\_

Contact name \_\_\_\_\_

Phone \_\_\_\_\_  
\_\_\_\_\_

Secondary insurance provider \_\_\_\_\_

Contact name \_\_\_\_\_

Phone \_\_\_\_\_  
\_\_\_\_\_

# Health Insurance Contacts

Date/time \_\_\_\_\_

Representative's name \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Purpose of call or letter \_\_\_\_\_

Comments \_\_\_\_\_

Follow-up \_\_\_\_\_

Date/time \_\_\_\_\_

Representative's name \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Purpose of call or letter \_\_\_\_\_

Comments \_\_\_\_\_

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\_\_\_\_\_

Follow-up \_\_\_\_\_

\_\_\_\_\_