Cancer Survivor

☐ Active treatment ☐ Completed treatment

Personal Information

Name

Phone

Address

Age: _____ Sex assigned at birth: _____ Height: _____

Emergency Contact

Name Phone

☐ Yes ☐ No I have a living will or a durable power of attorney for health care

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Allergies *(including reactions)*

Other Medical Conditions

Side Effects from Cancer Treatment

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Health Care Contacts

CANCER CARE TEAM

Name Phone

PRIMARY CARE PROVIDER (PCP)

Name Phone

PREFFERED HOSPITAL

Name

PHARMACY

Name Phone

Cancer Treatments *(current or past)*

Current Medications

(Include over-the-counter medications)

Name/Dosage/Frequency

FOLD HERE SECOND