

Cancer Records Checklist

Your name _____ Your birth date _____

Type of cancer _____ Date of diagnosis _____

How was your cancer found? (check one) By you Screening test Based on symptoms

Information about your type(s) of cancer treatment

Surgery

Date of surgery _____

Hospital/surgeon _____

Type of surgery _____

Chemotherapy

First treatment

Drug name(s) _____

Dates of treatment _____

Side effects _____

Results _____

Second treatment

Drug name(s) _____

Dates of treatment _____

Side effects _____

Results _____

Radiation therapy

Hospital/doctor _____

Part of body treated _____

Number of treatments _____

Side effects _____

Results _____

Hormone therapy

Name of medication _____

Date started/stopped _____

Side effects _____

Other treatments

Type of treatment _____

Dates of treatment _____

Side effects _____

Noncancer treatment medications you've taken or you're taking

Names _____

Doses _____

Complications _____

Medical professionals who've participated in your care

Names and phone numbers _____

Notes
