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|---|--------------------------------------|--|
| Date: | Name: | Age |
| Height: | Weight: | D.O.B. |
| Last appointment with Primary Doctor? | | Next? |
| Last appointment with Medical Oncologist? | | Next? |
| Did you have radiation? | Name of Radiation Oncologist: | |
| Please list NEW medical problems since cancer treatment (such as diabetes, high blood pressure, old stroke etc) | | |
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| Please list any NEW surgeries and procedures you've had since your cancer treatment: | | |
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| Are you allergic to any medications or foods? Please list: | | |
| Are you allergic to Latex? | | |
| Do you take aspirin daily or several times a week? | | |
| Do you take coumadin/warfarin? | | |
| Do you take prednisone or steroids? | | |
| Do you take herbs, roots, vitamins or medicinal tea? | | |
| Please write a list of any NEW medications (prescription or over the counter) that you take on a regular basis:(typed list is OK): | | |
| Name of Medication | Dose | How many times per day? |
| | | <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> as needed |
| | | <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> as needed |
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| If you were menstruating prior to cancer treatment, are you still having monthly cycles? | | |
| When are you due for your next mammogram? | | |
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|--|----------------|---------------|
| Date: | Name: | Age |
| Height: | Weight: | D.O.B. |
| Last appointment with Primary Doctor? | | Next? |
| Any new concerns or problems? | | |