Allergies

Other Medical Conditions

Notes

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I Have Cancer

Personal Information

NAME

PHONE

ADDRESS

Vitals

AGE: _____ SEX: _____ BLOOD TYPE: _____

HEIGHT: _____ WEIGHT: _____

Emergency Contact

NAME PHONE

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FOLD HERE FIRST

Current Treatments

Current Medications

(Include over-the-counter medications)

NAME/DOSAGE/FREQUENCY

FOLD HERE SECOND

Doctor Contacts

ONCOLOGIST

NAME PHONE

FAMILY DOCTOR

NAME PHONE

HOSPITAL

NAME PHONE

PHARMACIST/PHARMACY

NAME PHONE