



Knowing your medical history is crucial to practicing preventative healthcare following cancer treatment. This treatment summary was designed to help you keep track of your medical care. The information will encourage communication between you and your healthcare providers and promote good health. Providing every new doctor with an accurate medical history will ensure you are receiving essential follow-up care.

The growing number of childhood cancer survivors has improved awareness regarding potential medical late effects and the need for medical follow-up. Not all doctors will be familiar with your specific needs. Be your own best advocate by keeping a Treatment Summary, maintaining necessary medical follow-up and communicating with your healthcare team. If possible, you should attend a clinic designed specifically for childhood cancer survivors. This will not only ensure your needs are met, but will support research for future childhood cancer survivors.

For more information regarding late effects, late effects clinics and survivorship, visit The National Children's Cancer Society's survivorship Web site, www.beyondthecure.org.

We wish you continued success and health on your survivorship journey.

The Beyond the Cure Treatment Summary was completed in collaboration with Linda Rivard, R.N., Coordinator for the Pediatric Oncology Survivorship in Transition (POST) Clinic Advocate Hope Children's Hospital, Oak Lawn, Illinois.

Treatment Summary

Basic Information

Name: _____ Date of birth: _____

Gender: _____ Phone number: _____

Address: _____ City: _____ State: _____ Zip: _____

Current Medical Team

Primary doctor: _____ Phone number: _____

Address: _____ City: _____ State: _____ Zip: _____

Dentist: _____ Phone number: _____

Address: _____ City: _____ State: _____ Zip: _____

Other specialist: _____ Phone number: _____

Address: _____ City: _____ State: _____ Zip: _____

Other specialist: _____ Phone number: _____

Address: _____ City: _____ State: _____ Zip: _____

Medical History

To ensure the accuracy of the information, it is best if a member of your treatment team completes this section. If you are no longer in contact with the treatment facility, try to obtain a copy of your medical records and ask your current physician to help you complete the history. Make sure you are able to read and understand everything the medical professional completes. You should bring a copy of your medical history to each new doctor you see.

Oncologist: _____

Treating hospital: _____ Phone number: _____

Address: _____

City: _____ State: _____ Zip: _____

Diagnosis Information

Diagnosis: _____

Date of diagnosis: _____ Age at diagnosis: _____

Stage/classification: _____

Treatment start date: _____ Treatment end date: _____ Age at end of treatment: _____

Dates of relapse (if any): _____

Solid tumor (if applicable)

Primary site: _____

Metastasis site: _____

Leukemia (If applicable)

Age at diagnosis: _____

White blood count at diagnosis: _____

Risk group: _____

Lineage: _____

CNS status: _____

Cytology: _____

Treatment protocol or clinical trial number/title: _____

Surgery (if applicable)

Procedure: _____ Date: _____

Surgeon: _____

Hospital: _____ Phone number: _____

Address: _____ City: _____ State: _____ Zip: _____

Complications (if any): _____

Procedure: _____ Date: _____

Surgeon: _____

Facility: _____ Phone number: _____

Address: _____ City: _____ State: _____ Zip: _____

Complications (if any): _____

Procedure: _____ Date: _____

Surgeon: _____

Facility: _____ Phone number: _____

Address: _____ City: _____ State: _____ Zip: _____

Complications (if any): _____

Radiation

This section should be for radiation related to cancer treatment, but not include radiation related to bone marrow/stem cell transplant.

Area of body: _____

Start date: _____ Completion date: _____

Number of interruptions: _____

Radiologist: _____

Facility: _____ Phone number: _____

Address: _____ City: _____ State: ____ Zip: _____

Fractions (number of treatments): _____ Dose per fraction (treatment): _____

Total dose (cGy): _____ Type: _____ Blocks: _____

Area of body: _____

Start date: _____ Completion date: _____

Number of interruptions: _____

Radiologist: _____

Facility: _____ Phone number: _____

Address: _____ City: _____ State: ____ Zip: _____

Fractions (number of treatments): _____ Dose per fraction (treatment): _____

Total dose (cGy): _____ Type: _____ Blocks: _____

Chemotherapy (if applicable)

This section should be for chemotherapy related to cancer treatment, but not include chemotherapy related to bone marrow/stem cell transplant.

Oncologist: _____

Facility: _____ Phone number: _____

Address: _____ City: _____ State: _____ Zip: _____

Drug: _____

How administered: Oral / IV/ Intrathecal Cumulative dosage: _____

Drug: _____

How administered: Oral / IV/ Intrathecal Cumulative dosage: _____

Drug: _____

How administered: Oral / IV/ Intrathecal Cumulative dosage: _____

Drug: _____

How administered: Oral / IV/ Intrathecal Cumulative dosage: _____

Drug: _____

How administered: Oral / IV/ Intrathecal Cumulative dosage: _____

Drug: _____

How administered: Oral / IV/ Intrathecal Cumulative dosage: _____

Drug: _____

How administered: Oral / IV/ Intrathecal Cumulative dosage: _____

Adverse Drug Reactions/Allergies

Drug: _____

Reaction: _____

Hospitalization No Yes If yes, date of hospital stay(s): _____

Change in medications as a result of reaction: _____

Transfusion(s)

No Yes If yes, date(s) of transfusion(s): _____

Discuss implications with your doctor.

Bone-Marrow or Stem-Cell Transplants

Type of transplant: _____ Date(s) of transplant(s): _____

Transplant doctor: _____ Phone number: _____

Address: _____ City: _____ State: ____ Zip: _____

Pre-Transplant Radiation

Pre-transplant radiation regimens may cause unique late effects. In order to ensure proper medical follow up, these are listed separately.

Area treated: _____ Start date: _____

Completion date: _____ Interruptions: _____

Radiologist: _____

Facility: _____ Phone number: _____

Address: _____ City: _____ State: ____ Zip: _____

Fractions (number of treatments): _____ Dose per fraction (treatment): _____

Total dose (cGy): _____ Type: _____ Blocks: _____

Area treated: _____ Start date: _____

Completion date: _____ Interruptions: _____

Radiologist: _____

Facility: _____ Phone number: _____

Address: _____ City: _____ State: ____ Zip: _____

Fractions (number of treatments): _____ Dose per fraction (treatment): _____

Total dose (cGy): _____ Type: _____ Blocks: _____

Pre-Transplant Chemotherapy

Pre-transplant chemotherapy regimens may cause unique late effects. In order to ensure proper medical follow up, these are listed separately.

Oncologist: _____

Facility: _____ Phone number: _____

Address: _____ City: _____ State: _____ Zip: _____

Drug: _____

How administered: Oral / IV/ Intrathecal Cumulative dosage: _____

Drug: _____

How administered: Oral / IV/ Intrathecal Cumulative dosage: _____

Drug: _____

How administered: Oral / IV/ Intrathecal Cumulative dosage: _____

Drug: _____

How administered: Oral / IV/ Intrathecal Cumulative dosage: _____

Drug: _____

How administered: Oral / IV/ Intrathecal Cumulative dosage: _____

Drug: _____

How administered: Oral / IV/ Intrathecal Cumulative dosage: _____

Adverse Drug Reactions/Allergies

Drug: _____

Reaction: _____

Hospitalization No Yes If yes, date of hospital stay(s): _____

Change in medications as a result of reaction: _____

Complications from transplant: _____

Neuropsychological / Neurocognitive (if applicable)

Cancer treatment may lead to learning problems. In order to determine the impact of treatment, you may complete neuropsychological testing or another type of educational testing through your school system or hospital. This testing will help determine classroom modifications and suggestions for accommodations you may make throughout your life.

During Treatment

Psychiatrist: _____ Phone number: _____

Date of evaluations(s): _____ Results: _____

Recommendations made based on test results: _____

School: _____ Phone number: _____

Address: _____ City: _____ State: ____ Zip: _____

After Treatment

Psychiatrist: _____ Phone number: _____

Date of evaluations(s): _____ Results: _____

Recommendations made based on test results: _____

School: _____ Phone number: _____

Address: _____ City: _____ State: ____ Zip: _____

Complications During Therapy

Please select any complications and include a description. See glossary for clarification of unknown terms.

- Cardiac: _____

- Dental: _____

- EENT: _____

- Endocrine: _____

- GI/GU: _____

- GYN: _____

- Growth: _____

- Hepatic: _____

- Infections: _____

- Muscle/bone: _____

- Neurocognitive: _____

- Neurology: _____

- Nutrition: _____

- Orthopedic: _____

- Pulmonary: _____

- Renal: _____

- Skin: _____

Vascular: _____

Other: _____

Other: _____

Complications Following Therapy

Please select any complications and include a description. See glossary for clarification of unknown terms.

Cardiac: _____

Dental: _____

EENT: _____

Endocrine: _____

GI/GU: _____

GYN: _____

Growth: _____

Hepatic: _____

Infections: _____

Muscle/bone: _____

Neurology: _____

Nutrition: _____

Orthopedic: _____

- Pulmonary: _____

- Renal: _____

- Secondary malignant neoplasm: _____

- Skin: _____

- Vascular: _____

- Other: _____

- Other: _____

Health Survey

Make note of any problems you have had since your last medical appointment and bring an updated copy of this health survey to your follow up appointment. No matter how minor a complaint or body change may seem, you should document it and communicate it to your doctor.

<i>General</i>			<i>Date</i>	<i>Description</i>
Fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Weight gain	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Weight loss	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Fatigue	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Night sweats	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Sleep problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
 <i>Head</i>				
Headache	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Memory	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Other	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
 <i>Hearing</i>				
Hearing troubles	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Speech	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Ringing in ears	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
 <i>Eyes</i>				
Vision	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Cataracts	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Infection	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Dry eyes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Other	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____

Nose

- | | | | | |
|--------------------|-----------------------------|------------------------------|-------|-------|
| Sense of smell | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ | _____ |
| Bleeding | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ | _____ |
| Breathing | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ | _____ |
| Infection drainage | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ | _____ |
| Sinusitis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ | _____ |
| Other | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ | _____ |

Throat/Mouth

- | | | | | |
|-----------------------|-----------------------------|------------------------------|-------|-------|
| Taste | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ | _____ |
| Difficulty swallowing | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ | _____ |
| Infection | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ | _____ |
| Dry mouth | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ | _____ |
| Other | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ | _____ |

Neck

- | | | | | |
|--------|-----------------------------|------------------------------|-------|-------|
| Pain | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ | _____ |
| Masses | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ | _____ |
| Other | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ | _____ |

Heart & Lungs

- | | | | | |
|---------------------|-----------------------------|------------------------------|-------|-------|
| Shortness of breath | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ | _____ |
| Cough | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ | _____ |
| Chest pain | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ | _____ |
| Irregular heartbeat | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ | _____ |
| Infection | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ | _____ |

Are you able to keep up with your peers in competitive sports? No Yes

Family history of heart disease No Yes

Other: _____ No Yes

Gastro-Intestinal Tract

Appetite	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Bowel movement	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Diarrhea	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Constipation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Loss of appetite	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Weight loss	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Nausea	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Other	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____

Skin

Rashes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Sunburn	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Hair	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Dry skin	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Fragile nails	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Change in moles	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Skin changes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Other	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____

Neuro system

Dizziness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Fainting	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Numbness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Seizures	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____

Musculo-Skeletal System

Fractures	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Weakness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Cramps	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Arm, leg, foot/size difference	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Swelling of hands	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Difficulty walking	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Growth problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Bone pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Aches	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Other	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____

Allergies

To drugs	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
To food	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
To other	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____

Genital-Urinary

Urination	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Infection	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Lump in breast	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Other	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____

During this visit I would like these topics discussed: _____

Fertility

The fertility section will help you track basic reproductive information. Cancer and its treatment may or may not affect fertility. It is important that you share your medical history with your doctor as he or she may have specific concerns or comments related to your fertility.

Questions for females

Age at first period: _____ Mother's age at first period: _____

How often are your periods? _____ How long do your periods last? _____

Date of last period: _____ Date of last Pap smear: _____

Are your periods irregular or have you skipped periods? No Yes

Do you experience bleeding between periods or any discharge, pain or discomfort?

No Yes

Have you experienced hot flashes? No Yes

Do you use oral contraceptives? No Yes

Have you ever been pregnant? No Yes

If yes, # pregnancies: _____ # miscarriages: _____ # of abortions: _____

Questions for both sexes

Have you ever received reproductive counseling? No Yes

Do you have questions/concerns related to fertility? No Yes

Are you on any hormone replacement therapy? No Yes

Do you regularly practice self breast or testicular exams? No Yes

Lifestyle: Cigarettes or cigars No Yes

Alcohol No Yes

Street drugs No Yes

Sexually active No Yes

Birth control No Yes

Glossary

This glossary is provided to help eliminate the mystery behind medical terms and follow-up care. As with any profession, the medical community frequently utilizes acronyms. The acronyms found in the treatment summary are defined here.

Acromegaly - A disease caused by too much growth hormone in the body.

Cardiac - Pertaining to the heart.

CBC - Abbreviation for complete blood count.

Creatine clearance - Urine collection test to determine how well the kidneys are functioning.

cGy - Abbreviation for centigray. A unit of radiation equivalent to the older unit radiation.

CXR - Imaging test which provides valuable information about systems within the chest.

Cytogenetics - The study of chromosomes and chromosomal abnormalities.

Dexa - Imaging test to measure bone density.

EENT - Abbreviation for eye, ear, nose and throat.

Endocrine - Pertaining to the internal secretions, hormonal.

ESR - A test that measures the rate at which red blood cells settle through a column of liquid. This test is used to detect and monitor inflammation in the body.

Estradiol - A female hormone produced by the ovary.

FSH - Abbreviation for follicle stimulating hormone. Promotes maturation of ovarian follicles and in males' production of sperm.

GH - A hormone essential for growth.

GI - Abbreviation for gastrointestinal- pertaining to or communicating with the stomach and intestine.

GU - Abbreviation for genitourinary-pertaining to the genital and urinary organs.

GYN - Relating to the female.

Hepatic - Pertaining to the liver.

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hGH - Human growth hormone.

HIB - A bacterial infection.

Holter - A 24-hour portable monitor used to detect heart irregularities.

Intrathecal chemotherapy - Anticancer drugs that are injected into the fluid-filled space between the thin layers of tissue that cover the brain and spinal cord.

LH - Abbreviation for leutenizing hormone. Stimulates ovulation and in men is responsible for the production of testosterone.

Lipids - Fats stored in the body and used for energy.

Metastasis - The spread of cancer from one part of the body to another.

Neurology - The branch of science that treats the nervous system.

Neuropsychology - Looking at how the brain and nervous system relate to actual thoughts and behaviors.

PFT - Abbreviation for pulmonary function test which measures your lung function.

Pneumovax - Pneumonia vaccine.

Pulmonary - Pertaining to the lungs.

POCT - Measures bone density in the appendages.

Renal - Pertaining to the kidneys.

Solid tumor - An abnormal mass of tissue that usually does not contain cysts or liquid areas.

Somatomedin C - Test used to detect pituitary abnormalities, hGH deficiency, and acromegaly.

Stage - The extent of cancer in the body. Staging is usually based on the size of the tumor, whether lymph nodes contain cancer, and whether the cancer has spread from the original site to other parts of the body. (See NCI for descriptions relating to your specific cancer. Stages may be a combination of numbers, roman numerals and letters.)

T3 - A thyroid hormone that influences growth.

T4 - A thyroid hormone that regulates metabolism.

Testosterone - A male sex hormone.

TSH - A hormone that stimulates the release of thyroid hormone.

U/A - Urinalysis.

Vascular - Pertaining to the blood vessels.