niagarahealth
Extraordinary Caring. Every Person. Every Time.
Walker Family Cancer Centre

SELF REPORTING HISTORY

(Rev. 10/2021)

Affix patient label

Please answer the following questions. Bring your completed form to your first clinic visit.
If you are unsure of any information, a nurse will assist you before you see the doctor.

Name (as it is on your health card): _____ **Preferred name:** _____
Date of birth: _____ **Age:** _____

To which **gender** do you most identify? ☐Male ☐Female ☐Other _____

Is it ok to leave a message when we call you? ☐No ☐Yes

Email: _____

What language(s) do you speak? ☐English ☐French ☐Other _____

Do you need interpreter services? (eg. Language translation, sign language) ☐No ☐Yes

Do you have private insurance? ☐No ☐Yes Insurance Company: _____ Policy# _____

Present Problems

1. In your words, please explain the problem that has brought you here today:

_____

_____

2. What has your doctor told you about this problem?

_____

_____

3. Have you had surgery for this problem? ☐No ☐Yes (If yes, please explain including dates):

_____

_____

Health History

1. Have you had any major **health problems?**

☐Diabetes Year: ____ ☐Cancer Year: ____ ☐Heart Disease Year: ____ ☐High blood pressure Year: ____

☐Stroke Year: ____ ☐Tuberculosis Year: ____ ☐Kidney disease or Dialysis Year: ____

Other: _____

2. Do you have any health problems that are caused by a **viral** infection? (ex. HIV, Hepatitis, Epstein Barr)

☐No ☐Yes. If yes, please explain: _____

3. Do you have any **autoimmune disorders**? (ex. Ulcerative colitis, Crohn's, lupus, rheumatoid arthritis)

☐No ☐Yes. If yes, please explain: _____

4. Do you suffer from mental illness? ☐No ☐Yes. If yes, explain: _____

5. Have you had problems with substance abuse/addiction? ☐No ☐Yes. If yes, explain:

_____

_____

6. Have you had any **surgery or procedures**? ☐No ☐Yes. If yes, please explain (including approximate dates)

_____

_____

_____

7. Have you ever had a blood clot? ☐No ☐Yes. If yes, when? _____

8. Has anyone in your family ever had a blood clot? ☐No ☐Yes. If yes, who? _____

9. Do you have an implanted device? (ex. Pacemaker, defibrillator) ☐No ☐Yes. If yes, explain: _____

10. Are you using or thinking about using any other types of alternative or complimentary therapy?
(Ex. Herbal supplements, vitamins, therapeutic touch, etc.) ☐No ☐Yes
If yes, please list which ones and how often: _____

Social History

1. **Marital Status**: ☐Single ☐Married ☐Common Law ☐Divorced ☐Separated ☐Widowed

2. Do you have **children**? ☐No ☐Yes. If yes, how many? _____ Age(s) _____

3. **Home**: Where do you live? Who do you live with? _____

4. **Employment**: ☐Employed ☐Unemployed ☐Homemaker ☐Retired ☐Student
Where do you work? / Where did you work? _____

5. Do you have any religious/spiritual beliefs or cultural needs that you would like us to know about?
☐No ☐Yes. If yes, please explain _____

6. Do you identify Indigenous or have Indigenous ancestry? ☐No ☐Yes
If yes, would you like a referral to the Indigenous Navigator? ☐No ☐Yes ☐Not at this time
Do you plan to include traditional medicine in your plan of care? ☐No ☐Yes

7. Do you have a Power of Attorney for:
Personal Care ☐No ☐Yes Name: _____
Property (Finances) ☐No ☐Yes Name: _____

8. Would you like to see a **Social Worker** for:
Financial issues ☐No ☐Yes
Transportation issues ☐No ☐Yes
Power of Attorney ☐No ☐Yes

9. Our Supportive Care Team offers cancer-related counselling (ex. Emotional support, stress management, anxiety, relationship concerns, intimacy, body image). Would you and/or your family member/caregiver like a referral?
☐No ☐Yes. Explain if you wish: _____

10. Are you receiving health care services in your home? (ex. Nursing, personal care, homemaking, physiotherapy)
☐No ☐Yes. If yes, please explain: _____

11. Do you smoke? ☐No ☐Yes **OR** Have you ever smoked? ☐No ☐Yes
If yes, how many years have or had you smoked for? _____ When did you quit? _____
How many cigarettes do you or did you smoke in a day? _____

12. Do you drink alcohol? ☐No ☐Yes
If yes: How much? _____ How often? _____ What type? _____

13. Do you use recreational drugs? ☐No ☐Yes
If yes, How much? _____ How often? _____ What type? _____

Family History

1. Do you have a **family history** of cancer? ☐No ☐Yes ☐Unsure

If yes, please complete the chart below. We would like to know if your close blood relatives have had cancer: **mother, father, sister(s), brother(s), daughter(s), or son(s)**. For your extended family including **grandmother(s), grandfather(s), aunt(s), uncle(s)**, please state if they are from your maternal (mother's side) or paternal (father's side) of your family.

Relative (state if maternal/paternal)	**Type of Cancer**	**Comments**

2. Do you have any family history of kidney disease? ☐No ☐Yes

Family Planning/Gynecological History

1. Are you planning to have children in the future? ☐No ☐Yes
2. Are you and your partner using birth control? ☐No ☐Yes ☐not applicable
3. Are you having menstrual periods? ☐No ☐Yes ☐not applicable
4. If no, how old were you when your periods stopped? _____
5. How old were you when your periods started? _____
6. Have you ever taken hormones? ☐No ☐Yes. If yes, explain:
   (ex. Birth control pill, estrogen, premarin, provera, progesterone) _____

Review of Systems Do you have problems with:

Breathing: ☐No ☐Yes ☐Shortness of Breath ☐Cough _____

Skin: ☐No ☐Yes ☐Lesions ☐Moles ☐Rash _____

Vision: ☐No ☐Yes ☐Glasses ☐Cataracts ☐Glaucoma ☐Legally Blind _____

Hearing: ☐No ☐Yes ☐Deaf ☐Hearing Loss ☐Hearing aid ☐Right Ear ☐Left Ear

Walking: ☐No ☐Yes ☐Cane ☐Walker ☐Wheelchair _____

Bowels: ☐No ☐Yes ☐Constipation ☐Diarrhea ☐Bleeding _____

Bladder: ☐No ☐Yes ☐Peeing Often ☐Sudden Urge to Pee ☐Waking at Night to Pee _____

Nervous System: ☐No ☐Yes ☐Dizziness ☐Headaches ☐Loss of Muscle Function _____

Sleeping: ☐No ☐Yes ☐Too Much ☐Too Little _____

Other: _____

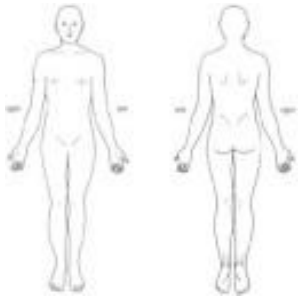
Pain History

1. Do you have pain? ☐No ☐Yes If yes, please complete the following:
2. Mark an "X" on the diagram to the right to show where your pain is:
3. Describe your pain (ex. Dull, sharp, throbbing, stabbing, gnawing)

_____

4. When do you have pain? ☐Sometimes ☐Most Times ☐All the Time

Front **Back**



5. Rate your pain using the scale below: (circle the number)

No pain		Mild pain		Moderate pain		Severe pain		Very severe pain		Worst possible
0	1	2	3	4	5	6	7	8	9	10

6. What makes your pain **better**? _____
7. What makes your pain **worse**? _____

Nutritional History

1. Do you consent to a dietitian referral if advised by your team?
   ☐No ☐Yes
2. Have you lost weight **without** trying in the last 3 months?
   ☐No ☐I am not sure ☐Yes
   If **YES**, how much weight have you lost? _____
3. Have you been eating poorly in the last **week** because of a decreased appetite? ☐No ☐Yes
4. Has your current problem caused changes in your normal diet? ☐No ☐Yes
   If yes, please explain (eating less, food intolerances, etc.) _____
5. Check the words to describe your diet

☐Normal ☐Liquid ☐Diabetic ☐Nutritional Drinks ☐Other _____

For Clinic Use Only

Second Ht _____ cm Wt _____ kg

Action:

Patient Care Needs:

Referrals to: _____ _____

Other: _____ _____

Reviewed by: _____ Date: _____