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

SELF REPORTING HISTORY (Revised 05/2019)

Please complete the following questions and return to the receptionist at your first clinic visit.
If you are unsure of any of the information, the nurse will review and assist you before you see the doctor.

Name: _____ **Age:** _____

Phone Number you can be reached at: _____

To protect your privacy we will not leave a message on an answering machine unless it identifies you by name.

Marital Status: Single ☐ Married ☐ Common Law ☐ Divorced ☐ Separated ☐ Widowed ☐

Children: No ☐ Yes ☐ If yes, how many _____ Ages_____

Contact Person: Name:_____Relationship:_____

Address: _____

Home Phone #: _____ Work/Other Phone #: _____

Alternate Contact: Name:_____Relationship:_____

Home Phone #:_____ Work/Other Phone #:_____

What **language(s)** do you speak? English ☐ French ☐ Italian ☐ German ☐ Other_____
Do you require an interpreter? Yes ☐ No ☐

Are you: **Employed** ☐ **Unemployed** ☐ **Retired** ☐ **Homemaker** ☐ **Student** ☐
Where do you work or where did you work?_____

Religion: _____
Do you have any religious/spiritual beliefs or cultural needs that you would like us to know about?
No ☐ Yes ☐ Please explain:_____

If you identify as Aboriginal, would you like access to our Aboriginal Navigator? ___no ___yes ___not at this time

Do you have a Power of Attorney for:
Personal Care Yes ☐ No ☐ Name:_____
Property (Finances) Yes ☐ No ☐ Name:_____
Copy of Power of Attorney documents given to nurse/doctor for placement on the chart? Yes ☐ No ☐

The Social Worker and/or Pharmacist are available to assist you with resource information.
Do you need information for: Financial issues (i.e. income) Yes ☐ No ☐
Medication issues Yes ☐ No ☐
Transportation issues Yes ☐ No ☐
Power of Attorney Yes ☐ No ☐

Where do you go for bloodwork? _____

Present Problem
1. Write in your words 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? Yes ☐ No ☐

If yes, please explain (include dates):_____

_____

Health Information (History)

1. Have you had any **surgery or procedure**? No ☐ Yes ☐
   If yes, check all that apply, include date:

Appendix ☐ year _____ Hysterectomy ☐ year _____ Gall bladder☐ year _____
Other:_____
_____

2. Have you had any major **health problems**?
No ☐ Yes ☐

Diabetes ☐ year _____ Cancer☐ year_____ Heart Disease ☐ year_____ High Blood Pressure ☐ year_____
Stroke☐ year_____ Tuberculosis ☐ year_____ Renal Impairment or Dialysis Treatment ☐ year_____
Other:_____

3. Do you have any **health problems** that affect your immune system? (Eg. Lupus, HIV, Hepatitis A/B/C, Epstein Barr virus)
No ☐ Yes ☐ If yes, please list: _____
_____
_____

4. Have you ever been screened for MRSA and/or VRE
No ☐ Yes ☐ If yes, what were the results: _____
_____

5. Are you using or thinking about using any other types of alternative or complimentary therapy?
   Eg. Herbal, vitamin, therapeutic touch, essiac, etc.
   No ☐ Yes ☐ If yes, please list which ones and how often: _____
_____

6. Do you have any **family history** of Cancer? No☐ Yes ☐
If yes, please complete the following:

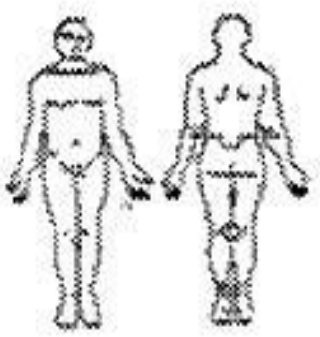
	mother	father	sister	brother	grandmother	grandfather	aunt	uncle
breast cancer								
bowel cancer								
lung cancer								
ovarian cancer								
other								

7. Do you have any **family history** of Renal Disease**?** No ☐ Yes ☐

Pain History

1. Do you have pain? No ☐ Yes ☐ If yes, please complete the following:

2. Mark an "X" on the diagram to show where your pain is:



3. Describe your pain (eg. dull, sharp, throbbing, stabbing, gnawing).
_____
_____

4. When do you have pain?
   Some of the time ☐ Most of the time ☐ All of the time ☐

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

no pain **mild pain** **moderate pain** **severe pain** **very severe pain** **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

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

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

8. Comments: _____

Psychological History

1. Please check the word(s) to describe how you are feeling (1 or more):

Worried ☐ Hopeful ☐ Depressed ☐
Scared ☐ Uncertain ☐ Angry ☐
Other _____

2. How much does your health problem change the way you feel about yourself or your body?

Not at all Very much
0 1 2 3 4 5 No answer ☐

3. Have you changed how you are with your partner? No ☐ Yes ☐ N/A ☐
Explain, if you wish: _____

4. Do you have any fears or concerns about:

Your Body No ☐ Yes ☐ No answer ☐
Intimacy No ☐ Yes ☐ No answer ☐

Explain, if you wish: _____

5. In the last year, were there major events or stressors in your life, other than your present problem?

No ☐ Loss of Job ☐ Family Wedding ☐ Move ☐ Retire ☐ Money ☐
Children left home ☐ Divorce/Separation ☐ Loss of Loved One ☐
Birth of child ☐ Family Illness ☐ Car Accident ☐ Other ☐
Explain, if you wish:_____

6. Who or what is most helpful when you are under stress? _____

7. How much is the stress of your present problem affecting you? (circle the number)

Not at all Very much
0 1 2 3 4 5

Nutritional History

1. Have you lost weight involuntarily in the last 3 months? No ☐ I am not sure ☐ Yes ☐
If yes, how much weight have you lost?

- ☐ 2.2 to 11 lbs
- ☐ 12 to 22 lbs
- ☐ 23 to 33
- ☐ > 33
- ☐ Unsure

2. Have you been eating poorly in the last **week** because of a decreased appetite?

- ☐ No
- ☐ Yes

3. Has your current problem caused changes in your normal diet? No ☐ Yes ☐
If yes, please explain: _____

4. Check the word(s) to describe your diet:

normal ☐ liquid ☐ diabetic ☐ nutrition drinks ☐
Other: _____

Social History

1. Do you currently smoke? No ☐ Yes ☐
2. Have you ever smoked? No ☐ Yes ☐
3. If yes, how many years have or had you smoked for? _____
4. How many cigarettes do you or did you smoke in a day? _____
5. Do you drink alcohol? No ☐ Yes ☐

If yes, please complete the following: How much? _____ How often? _____ What type? _____

Physiological History

1. Do you have problems with:

Respiratory: No ☐ Yes ☐ shortness of breath ☐ cough ☐ _____

_____

Skin: No ☐ Yes ☐ lesions ☐ moles☐ rash ☐ _____

_____

Vision: No ☐ Yes ☐ glasses ☐ cataracts ☐ glaucoma ☐ _____

_____

Hearing: No ☐ Yes ☐ loss ☐ hearing aid ☐ R ☐ L ☐ _____

_____

Walking: No ☐ Yes ☐ cane ☐ walker ☐ wheelchair ☐ _____

_____

Bowels: No ☐ Yes ☐ constipation ☐ diarrhea ☐ bleeding ☐ _____

_____

Bladder: No ☐ Yes ☐ frequency ☐ urgency ☐ night time ☐ _____

_____

Neurological: No ☐ Yes ☐ dizzy ☐ headaches ☐ paralysis ☐ _____

_____

Sleeping: No ☐ Yes ☐ too much ☐ too little ☐_____

Have you ever had a blood clot? No ☐ Yes ☐_____

Has anyone in your family ever had a blood clot? No ☐ Yes ☐_____

Are you receiving health care services in your home? No ☐ Yes ☐

(Eg. Nurse, homemaker, physiotherapy, oxygen, etc.) If yes, please explain: _____

Family Planning/Gyne History

1. Are you planning to have children in the future? No ☐ Yes ☐

2. Are you and your partner using any 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. Have you ever taken hormones? No ☐ Yes ☐

(Eg. birth control pill, estrogen, premarin, provera, progesterone)_____

For Clinic Use Only

CTC PS ____ ALO ____ N ____ V ____ DIA ____ CON ____ PNS ____ AME ____ HF____

Ht _____cm **Wt** _____kg **BP** _____

Patient Care Needs: Action:

1. _____ _____

2. _____ _____

Notes: _____

_____

_____

Reviewed By: _____ Date: _____