



Personal Health History

To complete this form electronically, please go to www.saskcancer.ca/patienthistory.

Name: _____ Personal Health Number: _____

Today's date: _____ Date of Birth: _____

Please answer the following questions to help us know about your health. Your answers will help us plan your care. The information provided will become a part of your health record and will be accessible to your healthcare providers.

MEDICAL HISTORY

Do you have any medical or health conditions? Check all medical or health conditions that apply or fill in the blanks.

None, no medical history

Condition	Age at Diagnosis	Condition	Age at Diagnosis	Condition	Age at Diagnosis
Arthritis	_____	<input type="checkbox"/> Hard of hearing	_____	<input type="checkbox"/> Migraines	_____
<input type="checkbox"/> Osteoid	_____	<input type="checkbox"/> Headaches	_____	<input type="checkbox"/> Osteoporosis	_____
<input type="checkbox"/> Rheumatoid	_____	<input type="checkbox"/> Heart attack	_____	<input type="checkbox"/> Pacemaker/ICD	_____
<input type="checkbox"/> Other: _____	_____	<input type="checkbox"/> Heart failure	_____	<input type="checkbox"/> Seizures	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> High blood pressure	_____	<input type="checkbox"/> Stroke/TIA	_____
<input type="checkbox"/> Benign prostatic hyperplasia	_____	<input type="checkbox"/> High cholesterol	_____	Thyroid problems	
<input type="checkbox"/> Blood clots	_____	<input type="checkbox"/> Inflammatory bowel disease	_____	<input type="checkbox"/> Hyperthyroid	_____
<input type="checkbox"/> Blood disorders/problems	_____	<input type="checkbox"/> Kidney disease	_____	<input type="checkbox"/> Hypothyroid	_____
<input type="checkbox"/> Cardiovascular disease	_____	Details: _____		Others: _____	_____
<input type="checkbox"/> COPD	_____	<input type="checkbox"/> Lupus	_____	_____	_____
Diabetes		Mental health		_____	_____
<input type="checkbox"/> Insulin	_____	<input type="checkbox"/> Anxiety	_____	_____	_____
<input type="checkbox"/> Non-Insulin	_____	<input type="checkbox"/> Depression	_____	_____	_____
<input type="checkbox"/> Epilepsy	_____	<input type="checkbox"/> Other: _____	_____		
<input type="checkbox"/> GERD	_____				

SURGICAL HISTORY

Have you undergone any surgical procedures, e.g. lung biopsy, colonoscopy, gall bladder removal, angiogram, etc.

None, no surgical or procedural history

Surgery or Procedure	Age	Surgery or Procedure	Age	Surgery or Procedure	Age

GYNECOLOGICAL HISTORY

Number of pregnancies: _____ Number of live births: _____ Age at first birth: _____

Age of first menstrual period: _____ Last menstrual period: _____ Age at menopause: _____

Hormone use:

None, no hormone use

Birth control pills

Number of years: _____

Post menopause use

Number of years: _____

Other use: _____

Number of years: _____

Date of last mammogram: _____

Date of last Pap test: _____



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FAMILY HISTORY

Do you have children? No Yes Number of sons: _____ Number of daughters: _____

Are all alive and well? If not, please provide details: _____

Do you have siblings? No Yes Number of brothers: _____ Number of sisters: _____

Please indicate the following known family diagnosis: **cancer**, blood disorders/bleeding problems, cardiovascular disease, diabetes.

None, no remarkable family history

Mother's side (mother, aunts, uncles, cousins, grandparents)

Relation	Medical Problem	Age at Diagnosis	Alive (Yes/No)	Age at Death	Cause of Death

Father's side (father, aunts, uncles, cousins, grandparents)

Relation	Medical Problem	Age at Diagnosis	Alive (Yes/No)	Age at Death	Cause of Death

Brothers and sisters

Relation	Medical Problem	Age at Diagnosis	Alive (Yes/No)	Age at Death	Cause of Death

Children

Relation	Medical Problem	Age at Diagnosis	Alive (Yes/No)	Age at Death	Cause of Death



SOCIAL HISTORY

Do you smoke or chew tobacco?

- No, never Unknown
Yes, current every day smoker # of years: # of packs/day:
Yes, current some days smoker # of years: # of packs/day:
Yes, but I have quit # of years quit: # of years smoked: # of packs/day:

Products

- Cigarettes Cigars Chewing tobacco E Cigarettes Marijuana/cannabis
Pipe Snuff Recreational drug use Intravenous drug use

For current tobacco users: Quitting smoking and removing second-hand smoke has health benefits for cancer patients whether or not you need cancer treatment. Tobacco cessation services are available through community pharmacists.

Do you consent to be referred to a pharmacist for tobacco cessation services? Yes No

If yes, name and location of your preferred pharmacy:

Do you drink alcohol?

- No, never Unknown
Yes, current every day drinker # of days/week: # of drinks/day:
Yes, current some days drinker # of days/week: # of drinks/day:
Yes, but I have quit # of years quit: # of days/week: # of drinks/day:

Environmental exposure (check all that apply)

- Agricultural chemicals Asbestos Lead Radiation Radon Second-hand smoke
Other:

Marital status

- Single Married Common law Separated Divorced Widowed

Occupation:

Living arrangements

Do you live alone? Yes No, I live with:

Type of residence: Own home Nursing home/long-term care Assisted living environment
Other:

Are you able to look after yourself independently? Yes No, I need help with:

Do you currently have homecare? Yes No Palliative

Are you able to attend your appointments? Yes No

If no, please provide details:

Mobility

- Use cane Use walker Use wheelchair

OTHER

Have you ever been treated for: MRSA VRE ESBL? If yes, when:

Information provided by: Patient Relative Other:

If you have an advanced healthcare plan (living will) with medical power of attorney, or a healthcare proxy, please bring a copy with you to your new patient appointment.

If you would like to email the form, send the completed form to patienthistory@saskcancer.ca and include your city/town in the subject line.