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
Arthritis	
❒ Osteoid	_____
❒ Rheumatoid	_____
❒ Other: _____	_____
❒ Asthma	_____
❒ Benign prostatic hyperplasia	_____
❒ Blood clots	_____
❒ Blood disorders/ problems	_____
❒ Cardiovascular disease	_____
❒ COPD	_____
Diabetes	
❒ Insulin	_____
❒ Non-Insulin	_____
❒ Epilepsy	_____
❒ GERD	_____

Condition	Age at Diagnosis
❒ Hard of hearing	_____
❒ Headaches	_____
❒ Heart attack	_____
❒ Heart failure	_____
❒ High blood pressure	_____
❒ High cholesterol	_____
❒ Inflammatory bowel disease	_____
❒ Kidney disease Details: _____	_____
❒ Lupus	_____
Mental health	
❒ Anxiety	_____
❒ Depression	_____
❒ Other: _____	_____

Condition	Age at Diagnosis
❒ Migraines	_____
❒ Osteoporosis	_____
❒ Pacemaker/ICD	_____
❒ Seizures	_____
❒ Stroke/TIA	_____
Thyroid problems	
❒ Hyperthyroid	_____
❒ Hypothyroid	_____
Others:	
_____	_____
_____	_____
_____	_____
_____	_____

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: _____

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

Personal Health History

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

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

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, please send the completed form to patienthistory@saskcancer.ca and include your city/town in the subject line.