CANOPY CANCER CARE

Name: _____
(Last Name) (First Name)

NHI: _____ DOB: _____

Gender: Male ☐ Female ☐ Date: _____

PATIENT HEALTH HISTORY

Weight: _____ kg Height: _____ cm

Do you have any allergies or sensitiveness to any medications, food, latex, Sticking plasters or other? Y ☐ N ☐

Medication/Substance Name	Type of Reaction

1. Do you smoke or have you ever smoked? Y ☐ N ☐
   If yes, how many a day, for how many years and how long ago? _____
2. Do you drink alcohol? Y ☐ N ☐
   If yes, how much and how often? _____
3. Do you have vision or hearing difficulties? Y ☐ N ☐
   If yes, please describe: _____
4. Do you have any religious beliefs/practices or cultural needs we should be aware of? Y ☐ N ☐
   If yes, please describe: _____
5. Do you have any skin problems (eg ulcers, bruise easily, wounds or dressings)? Y ☐ N ☐
   If yes, please describe: _____
6. Mobility:
   Independent ☐ Using Equipment ☐ Requiring Assistance ☐ Completely dependent ☐
   Please specify: _____
7. Do you take any regular medications? (including the contraceptive pill, inhalers, herbal remedies, pain medication, eye drops, sprays or regular over the counter medications such as aspirin). ***List below***

Medication	Strength (mg)	Dose (how many)	Frequency (how often)

continued over

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Name: _____
(Last Name) (First Name)

NHI: _____

PATIENT HEALTH HISTORY (cont)

9. Do you have high blood pressure? Y ☐ N ☐
If yes, is this being monitored/treated by your GP? _____

10. Do you have any heart problems (eg heart attack, angina, irregular pulse, fluid on lungs, pacemaker, rheumatic fever, palpitations, fainting, murmur, endocarditis)? Y ☐ N ☐
If yes, please list: _____

11. Do you have any blood disorders: (eg anaemia, Von Willebrands disease)? Y ☐ N ☐
If yes, please explain: _____

12. Do you have asthma? Y ☐ N ☐

13. Do you have lung problems (eg recent bronchitis, emphysema, TB)? Y ☐ N ☐

14. Have you had a stroke (eg CVA, or TIA)? Y ☐ N ☐

15. Have you ever had any fits or seizures (eg epilepsy)? Y ☐ N ☐
If yes, when was your last seizure: _____

16. Please tick if applicable:
Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Yellow jaundice ☐ HIV ☐

17. Do you have diabetes? Y ☐ N ☐
If yes, what treatment are you on?: (circle) Diet Tablets Insulin

18. Do you have or have ever had any blood clots to legs or lungs? Y ☐ N ☐

19. Do you have rheumatoid Arthritis? Y ☐ N ☐

20. Do you have: Hiatus Hernia ☐ Heartburn ☐ Acid Reflux ☐

21. Are you, or could you be, pregnant? Y ☐ N ☐
If yes, how many months: _____

22. Do you have any family history of cancer? Y ☐ N ☐
If yes, please specify: _____
_____
_____
_____
_____

23. Are there any other medical conditions (eg Alzheimer's, psychiatric history)? Y ☐ N ☐
If yes, please specify: _____

24. Have you ever had surgery? Y ☐ N ☐
If yes, please specify: _____