Patient Health History Form

canopy cancer care

Name: _____ Date of Birth: _____
(First name) (Last name)

Gender: _____ **Weight (kg):** _____ **Height (cm):** _____

Date form completed: _____

Do you currently have, or have you had, any of the following illnesses or conditions? Please tick.

Endocrine
- ◯ Diabetes
- ◯ Thyroid Disorder
- ◯ Other – please specify

_____

Heart Conditions
- ◯ Artery/ vein problems
- ◯ Chronic congestive heart failure
- ◯ Heart attack
- ◯ Heart disease
- ◯ Heart valve problems
- ◯ High blood pressure
- ◯ Pacemaker
- ◯ Palpitations
- ◯ Rheumatic Fever
- ◯ Varicose veins
- ◯ Other – please specify

_____

Haematology (Blood Conditions)
- ◯ Bleeding Disorders
- ◯ Blood clots
- ◯ Other – please specify

_____

Immune Conditions
- ◯ Autoimmune Disease
- ◯ Other – please specify

_____

Infectious Diseases
- ◯ Tuberculosis
- ◯ Other – please specify

_____

Mental Health
- ◯ Anxiety/Mood Disorder
- ◯ Depression
- ◯ Other – please specify

_____

Neurological
- ◯ History of headaches/migraines
- ◯ Stroke/TIA
- ◯ Seizures/ Epilepsy Disorder
- ◯ Other – please specify

_____

Bone/Joint Conditions
- ◯ Arthritis
- ◯ Osteoporosis
- ◯ Other – please specify

_____

Respiratory (Lung Conditions)
- ◯ Asthma
- ◯ Chronic Cough
- ◯ Chronic Obstructive Pulmonary Disease (COPD)
- ◯ Emphysema
- ◯ Other – please specify

_____

Patient Health History Form

canopy cancer care

Name: _____ Date of Birth: _____
(First name) (Last name)

Please answer all the following questions by ticking the appropriate Yes/No box. If the answer is YES, please give details in the space provided.

Please answer all questions

1. What is the main symptom you currently have?

2. Do you have any religious beliefs/practices or cultural needs that you would like us to be aware of?

◯ Yes ◯ No

If yes, please specify:

3. Are you a current smoker of tobacco?

◯ Yes ◯ No

If yes, number per day? For how many years?

4. Do you consume alcohol?

◯ Yes ◯ No

If yes, how many drinks per day/week?

5. Do you take recreational drugs? (e.g. cannabis, heroin, methamphetamine)?

◯ Yes ◯ No

If yes, please specify:

6. Do you have vision or hearing difficulties?

◯ Yes ◯ No

If yes, please specify:

7. Mobility

◯ Independent ◯ Requiring Assistance
◯ Using Equipment ◯ Completely dependent

Patient Health History Form

canopy cancer care

Name: _____ Date of Birth: _____
(First name) (Last name)

8. Do you feel unsteady when standing or walking?

◯ Yes ◯ No

---

9. Have you fallen in the last year?

◯ Yes ◯ No

If yes, how many times? Please specify any injuries:

---

10. Are you able to perform activities of daily living independently (e.g. showering, dressing, cooking, cleaning)?

◯ Yes ◯ No

If no, please specify:

---

11. Are you, or could you be pregnant?

◯ Yes ◯ No

If yes, how many months?

---

12. Do you have any family history of cancer?

◯ Yes ◯ No

If yes, please specify:

---

13. Have you been eating less food than usual because you have not been hungry?

◯ Yes ◯ No

---

14. Within the last 6 months, have you lost weight without trying?

◯ Yes ◯ No

If yes, how much weight have you lost?

---

14. Have you ever had surgery?

◯ Yes ◯ No

If yes, please specify:

Patient Health History Form

canopy cancer care

Name: _____ Date of Birth: _____
(First name) (Last name)

Do you have any allergies or sensitivities to any medication, food, latex, sticking plasters or other?

◯ Yes ◯ No

Medication/Substance Name	Type of Reaction

Do you take any regular medications? List Below:
(including the contraceptive pill, inhalers, herbal remedies, health supplements, pain medication, eye drops, sprays or regular over the counter medications such as aspirin)

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

MEDICAL-IN-CONFIDENCE

This correspondence is confidential and is intended solely for the use of the individual or entity to who it is addressed. If you have received it in error please notify **Canopy Cancer Care** on **09 623 5602** and destroy any copies.