MEDICAL-IN-CONFIDENCE

Patient health history form

CANOPY CANCER CARE

Name: _____
(Last name) (First name)

DOB: _____ Gender: _____

Weight: _____ **kg** **Height:** _____ **cm** **Date:** _____

1. Do you have any allergies or sensitiveness to any medications, food, latex, sticking plasters or other?
◯ Y ◯ N

Medication/Substance Name	Type of Reaction

2. Do you smoke or have you ever smoked? ◯ Y ◯ N
If yes, how many a day, for how many years and how long ago?

3. Do you drink alcohol? ◯ Y ◯ N
If yes, how much and how often?

4. Do you have vision or hearing difficulties? ◯ Y ◯ N
If yes, please describe:

5. Do you have any religious beliefs/practices or cultural needs we should be aware of? ◯ Y ◯ N
If yes, please describe:

6. Do you have any skin problems (eg ulcers, bruise easily, wounds or dressings)? ◯ Y ◯ N
If yes, please describe:

7. Mobility: ◯ Independent ◯ Using Equipment ◯ Requiring Assistance ◯ Completely dependent
Please specify:

8. 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)

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Patient health history form - continued

CANOPY CANCER CARE

Name: _____
(Last name) (First name)

DOB: _____ Gender: _____

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

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

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

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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)? If yes, when was your last seizure: ◯ Y ◯ N

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16. Please tick if applicable?

◯ Hepatitis A ◯ Hepatitis B ◯ Hepatitis C ◯ Yellow jaundice ◯ HIV

17. Do you have diabetes? If yes, what treatment are you on? ◯ Y ◯ N

◯ 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:

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

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

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

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25. Have you been vaccinated against COVID-19? ◯ Y ◯ N
If Yes, please confirm how many doses and the date:

◯ 1st: _____ ◯ 2nd: _____ ◯ 3rd: _____