The Ottawa Hospital | L'Hôpital d'Ottawa

SELF-REPORTING HEALTH HISTORY

CIVIC CAMPUS Grimes Lodge, 5th floor, 200 Melrose Ave., Ottawa, ON K1Y 4K7

❑ **Ottawa Regional Women's Breast Health Centre**
Tel.: 613-761-4400 Fax: 613-761-4994

GENERAL CAMPUS 501, Smyth Rd, Ottawa ON K1H 8L6

❑ **Cancer Assessment Clinic** Tel.: 613-737-8501 Fax: 613-737-8643
Diagnostic Units for Lung, Colorectal and Prostate Cancer - 7th floor

❑ **Cancer Centre-Centre de cancérologie**

Preferred language: ❑ English ❑ French ❑ Other:

RESERVED FOR INTERVIEWER USE

Interview information

1. What is the health problem that has led you to coming to our centre?

_____

_____

_____

2. What is your main concern today?

_____

❑ No problems
❑ Referral to

Interview information

Medication allergies	**Reactions**
Substance or food allergies	**Reactions**

❑ No allergies
❑ Pharmacy notified of allergy

Interview information

3. Has anyone in your family (blood relatives only) had cancer? ❑ No ❑ Yes

Relationship to you (indicate mother or father's side)	**Original location of cancer**	**Age at diagnosis**

❑ No problems
❑ Referral to

Interview information

MEDICATION Community pharmacy name: _____ tel. no.: _____

4. Are you currently taking any medication (prescriptions or over-the-counter medicine)? ❑ No ❑ Yes

Medication (name)	Strength	Dose	How often	Purpose

❑ No problems
❑ Referral to

Patient : Chart no.:

5. Check your relevant medical history (✔)	Date of onset	Symptoms	Interview information
❑ Cancer (type):			
❑ Heart disease			
❑ Hypertension			
❑ Lung disease			
❑ Liver disease			
❑ Kidney disease			
❑ Thyroid disease			
❑ CVA (stroke)			
❑ Diabetes			
❑ Bleeding disorder			
❑ Arthritis			
❑ Dementia			
❑ G.I. problems			
❑ Psychiatric			
❑ Other			

6. List your prior surgeries Date Surgeries Date

❑ No problems
❑ Referral to

7. Do you smoke?
   ❑ Yes How long have you smoked? _____ How many cigarettes a day? _____
   ❑ No Did you ever smoke? ❑ Yes ❑ No
   If yes, when did you quit? _____
   How long did you smoke? _____
   How many cigarettes a day? _____

Interview information

8. Did you have any exposure to asbestos? _____ year ❑ No ❑ Yes

9. Do you use alcohol? _____ drinks / week ❑ No ❑ Yes

10. Are you on a special diet (include cultural dietary practices)? ❑ No ❑ Yes
    If yes, specify: _____
    _____

11. Have you had a recent change in your weight? ❑ No ❑ Yes
    If yes, gained _____ kg/lbs Lost _____ kg/lbs

12. Do you have any problems with swallowing? ❑ No ❑ Yes
    If yes, describe: _____
    _____

13. Are you blind or do you have limited sight? ❑ Wear glasses ❑ No ❑ Yes

14. Do you have trouble hearing? ❑ Wear a hearing aid ❑ No ❑ Yes

15. Do you use a wheelchair/motorized chair/walker? ❑ No ❑ Yes

❑ No problems
❑ Referral to

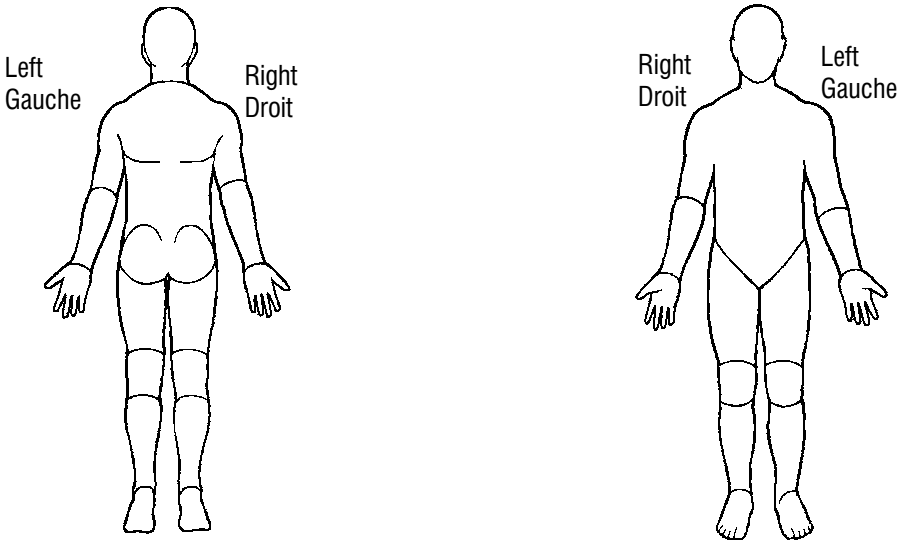
PAIN

Interview information

16. Do you have pain? ❑ No ❑ Yes
    If yes, when do you have pain?
    _____

17. Check the word(s) that describe your pain:
    ❑ Piercing ❑ Aching ❑ Shooting ❑ Burning ❑ Cramping
    ❑ Stinging ❑ Comes/goes ❑ Other: _____

18. Please mark on the picture where you have pain.



19. What are you doing to decrease your pain?
    _____

20. Is the pain under control? ❑ No ❑ Yes

❑ No pain
❑ Brief pain inventory completed(Score 0-10)
_____
❑ Referral to

SUPPORT

Interview information

21. What is your marital/couple status? ❑ Single ❑ Married ❑ Divorced
    ❑ Common law ❑ Widowed ❑ Other: _____
    Who lives with you (spouse, partner, children, friends)? _____
    If you have any children, what are their ages? _____

22. Who do you rely on the most for support or help?
    Name of person _____ Relationship: _____

23. Do your family members know about your health status? ❑ No ❑ Yes

24. Are family members having trouble coping with your health status? ❑ No ❑ Yes
    If yes, would you like help for family members? ❑ No ❑ Yes
    If you wish, please explain: _____

25. What type of work do you do (did you do)? _____
    Are you: ❑ Self-employed ❑ Employed ❑ Full-time ❑ Part-time
    ❑ Homemaker ❑ Retired ❑ Student ❑ Unemployed

26. In the last year, were there major events or stresses in your life, other than your present problem?
    ❑ No ❑ Loss of job ❑ Family wedding ❑ Children left home
    ❑ Divorce/separation ❑ Loss of loved one ❑ Birth of child
    ❑ Family illness ❑ Car accident ❑ Move ❑ Retired
    ❑ Other. If you wish, please explain: _____

27. Circle how much distress your present problem has caused.
    Not at all 0 1 2 3 4 5 Very much ❑ No answer

Patient : Chart no.:

28. Please check the word(s) that describe how you are feeling (1 or more):
❑ Anxious ❑ Hopeful ❑ Optimistic ❑ Depressed ❑ Relieved ❑ Scared
❑ Uncertain ❑ Angry ❑ Other:

29. Would you like to see a counsellor for support in adjusting to your diagnosis? ❑ No ❑ Yes
Would you like to attend a support group? ❑ No ❑ Yes

30. Do you want to have children in the future? ❑ No ❑ Yes
❑ Unsure ❑ Not applicable
If yes, would you like information on fertility resources? ❑ No ❑ Yes

31. a Are you or your partner using birth control? ❑ Not applicable ❑ No ❑ Yes
(tubes tied, vasectomy, the pill, IUD, condoms, diaphragm)
b Are you currently pregnant? ❑ Not applicable ❑ No ❑ Yes
If you are a woman of childbearing potential (currently menstruating or within 1 year of menopause) and are uncertain if you might be pregnant, please discuss this with your family physician, oncologist or nurse and ensure that a pregnancy test is performed. ***It is important NOT to receive treatment (chemotherapy and/or radiotherapy) if you are pregnant.***

32. Do you have any sexual intimacy concerns that you would like to discuss with:
❑ a physician OR ❑ a counsellor ❑ No ❑ Yes

33. Do you have any concerns (e.g. financial, self care, child care, employment, family responsibilities)?
If yes, please specify _____ ❑ No ❑ Yes

34. Do you have any beliefs (religious or cultural) that we should know about when providing care?
If yes, please explain: _____ ❑ No ❑ Yes

35. Are you receiving health care services in your home (nurse, personal care worker, physiotherapist)?
If yes, please explain: _____ ❑ No ❑ Yes

36. Have you given someone power of attorney for your personal care?
If yes, please explain: _____ ❑ No ❑ Yes
If no, would you like information on power of attorney? ❑ No ❑ Yes

37. Do you need in formation on loss of income support during treatment? ❑ No ❑ Yes

38. Who pays for your medication?
❑ A private insurance plan ❑ No coverage
Name of company: _____
❑ Seniors Benefits Government Assistance Program ❑ Trillium Drug Program

39. Do you need help with getting to and from the Centre? ❑ No ❑ Yes

Interview information

❑ Referral to Social Work if score ≥ 5.

❑ RN verified female patient states "she is not pregnant currently"
date: _____
initials: _____

❑ If yes, give brochure on income loss

❑ If no coverage give Trillium Application Form

❑ No problems
❑ Referral to

Thank you for completing this form. Please give it to the nurse on your first visit to the Centre.

Completed by (state relationship to patient if not patient):
Signature **Relationship** **Date (yyyy/mm/dd)**

Reviewed by:
Signature **Status** **Date (yyyy/mm/dd)**

CARE TEAM TO COMPLETE REFERRALS MADE TO:

❑ **Pain and symptom management** ❑ **Social work** ❑ **APN:** ❑ **Lung** ❑ **GI** ❑ **Breast**
❑ **CCAC** **CCS:** ❑ **Volunteer driver** ❑ **Peer support** ❑ **Palliative care physician**
❑ **Dietitian (only head and neck plus patient with significant weight loss)** ❑ **Psychiatry**