SAULT AREA HOSPITAL / HÔPITAL DE SAULT-SAINTE-MARIE | ALGOMA DISTRICT CANCER PROGRAM

Algoma District Cancer Program Patient Data Form

BP ________ Pulse ________ Resp ____________ Height __________ cm Weight __________ Kg

Allergies: ____

DEMOGRAPHIC INFORMATION		
First Name:	Middle Initial:	Last Name:
Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Other:____________	
Patient's Occupation:	Company:	
Partner's Occupation:	Company:	
Living Arrangements/ Care Providers:		
Emergency Contact:	Emergency Contact Telephone Number:	
Patient Phone: Home:	Work:	Cell:
Do you have any advance directives? ☐ Yes ☐ No		
Do you have a Power of Attorney? ☐ Yes ☐ No	If yes, Name:	Phone Number:
Language(s) Spoken:	Language(s) Read:	Language(s) Understood:
How do you learn best?	☐ Reading ☐ Audio/ Video ☐ Pictures ☐ Explanation ☐ Other:	
Do you have religious/cultural practices you would like us to know about? ☐ No ☐ Yes:		
What is your ethnicity/background/race?		
Aboriginal Ancestry Status (please check):	☐ Non-Status ☐ Status ☐ Métis ☒ Inuit	

TOBACCO and ALCOHOL USE	
Have you used tobacco in the last 6 months? ☐ No ☐ Yes _____ cigarettes/day Are you ready to make a quit attempt at this time? ☐ No ☐ Yes ____________________________	Do you drink alcoholic beverages? ☐ No ☐ Yes _______ drinks/week _______ drinks/month

NOTE: This is a **CONTROLLED** document as are all files on this server. Any documents appearing in paper form are not controlled and should **ALWAYS** be checked against the server file versions (electronic version) prior to use
Health Records – Do Not Destroy

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PERSONAL and FAMILY MEDICAL HISTORY				
Condition	**I Have Now**	**I Had Before**	**Family**	**Date/Comments**
Angina/Heart Attack				
High Blood Pressure				
Stroke				
Phlebitis/Inflamed Veins				
Congestive Heart Failure				
Asthma/Emphysema/COPD				
Seizures				
Sleep Disorder				
Mental Illness				
Diabetes				
Arthritis/Gout				
Kidney Disease				
Thyroid Disease				
Infectious Disease (e.g. HIV, Hepatitis C, Tuberculosis)				
Muscle Disorder				
Blood Disorder				
Ulcer/GERD				
Celiac Disease				
Skin Problems				
Jaundice/Liver Disease				
Irritable Bowel Disease				
Scleroderma				
Lupus				
Other:				

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PAST SURGERIES:			
Surgery	**Date**	**Surgery**	**Date**

PERSONAL CANCER HISTORY		
Cancer Type	**Age at Diagnosis**	**Treatment Used**

FAMILY CANCER HISTORY			
Cancer Type	**Relative**	**Living (Yes/No)**	**Age at Diagnosis**

NUTRITION ASSESSMENT				
Have you lost weight within the past 6 months without trying: ☐ Yes ☐ No ☐ Unsure				
Yes How many pounds?	1-10	11-20	21-30	>30
Have you been eating poorly because of a decreased appetite? (less than ½ of usual intake) ☐ No ☐ Yes				
Are you having any difficulty swallowing foods or fluids? ☐ No ☐ Yes (if yes, fill out Speech Language Pathologist Referral)				
When was your last **Dental Check Up**?				

SENSES: Do you require any of the following:					
Glasses or contact lenses?	☐ Yes	☐ No	Brace?	☐ Yes	☐ No
Wheelchair?	☐ Yes	☐ No	Walker?	☐ Yes	☐ No
Hearing aid(s)?	☐ Yes	☐ No	Cane?	☐ Yes	☐ No

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PSYCHOSOCIAL ASSESSMENT		
Coping/Emotional Support Please indicate by checking the boxes if you require information for any of the following:		
☐ Counseling – individual, family	☐ Caregiver support	☐ Relationship problems
☐ Legal/financial resource assistance	☐ Power of Attorney/Wills	☐ Stress Management
Pain / Symptom Management Referral	Palliative Care Referral	Other

Canadian Problem Checklist

Please check all of the following items that have been a concern or problem for you in the past week, including today:

Practical
- ☐ Work/School
- ☐ Finances
- ☐ Getting to and from appointments
- ☐ Accommodation

Emotional
- ☐ Fears/Worries
- ☐ Sadness
- ☐ Frustration/Anger
- ☐ Changes in appearance
- ☐ Intimacy/Sexuality

Social/Family
- ☐ Feeling a burden to others
- ☐ Worry about family/Friends
- ☐ Feeling alone

Informational
- ☐ Understanding my illness and/or treatment
- ☐ Talking with the health-care team
- ☐ Making treatment decisions
- ☐ Knowing about available resources

Spiritual
- ☐ Meaning/Purpose of life
- ☐ Faith

Physical
- ☐ Concentration/Memory
- ☐ Sleep
- ☐ Weight

Source: Canadian Partnership Against Cancer, Cancer Journey Action Group Guide to Implementing Screening for Distress, the 6th Vital Sign: Moving Towards Person-Centered Care. Part A. Background, recommendations and implementation. Toronto, ON: The Partnership; 2009.

SEXUAL HEALTH ASSESSMENT		
Are you sexually active?	☐ Yes	☐ No
Do you have concerns with sexual function?	☐ Yes	☐ No
Are you planning a family in the near future?	☐ Yes	☐ No
Are birth control measures used? What kind? ________________________________	☐ Yes	☐ No
For Female Patients:		
Do you do regular breast self-examinations?	☐ Yes	☐ No
How many times have you been pregnant?		
Did you breastfeed your children?	☐ Yes	☐ No
If yes, for how long?		
Have you ever used hormones or birth control pills?	☐ Yes	☐ No
Age at first menstrual period?		
Age of menopause (last menstrual period)?		
When was your last PAP test?		
For Male Patients		
Do you do regular testicular self-examinations?	☐ Yes	☐ No
When was your last prostate exam?		

Date Completed (YYYY/MM/DD): ______________________________ Completed by: ______________________