breast rehab

health history form

Patient Name

....

OHIP # **Date of Birth**

.... (DD/MM/YYYY) ....

Telephone

[H] ( ) [W] ( ) [C] ( )

Address **Email address**

....

....

....

Preferred method of appointment reminder: ○ Email ○ Phone Call ○ Text Message

Where did you first hear about us?

○ doctor ○ internet ○ pamphlet ○ friend ○ patient

○ other ....

Did someone refer you? ○ yes ○ no

If yes, who? ....

Doctors	Name	Address
Family Doctor	....	....
Referring Physician	....	....
Specialist	....	....

What are you seeking treatment for?

....

Have you or are you seeing any other health care practitioner(s) for this problem? ○ yes ○ no

If yes, who? ....

Lifestyle

	Never	Occasionally	Weekly	Daily		Never	Occasionally	Weekly	Daily
Smoke	○	○	○	○	**Meditate/ Yoga**	○	○	○	○
Drink Alcohol	○	○	○	○	**Feel Stressed**	○	○	○	○
Exercise	○	○	○	○	**Sleep Well**	○	○	○	○
Drink Caffeine	○	○	○	○	**Have fun**	○	○	○	○

Occupation .... **Height** .... **Weight** .... **BMI** ....

Please list all physical activities you participate in on a regular basis

Activity	Days per week	Hours per day

Please list all surgical operations, starting with the most recent

Operation	Surgeon	Date
....	....	(DD/MM/YYYY)
....	....	(DD/MM/YYYY)
....	....	(DD/MM/YYYY)
....	....	(DD/MM/YYYY)
....	....	(DD/MM/YYYY)

Please complete the following table (if applicable)

Test	Region of body	Date
Ultrasound	....	(DD/MM/YYYY)
X-ray	....	(DD/MM/YYYY)
CT Scan	....	(DD/MM/YYYY)
MRI	....	(DD/MM/YYYY)
Bone Scan	....	(DD/MM/YYYY)
Echocardiogram	....	(DD/MM/YYYY)

Do you have any allergies? ○ yes ○ no

If so, please specify ....

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Please list all medications

Medication name	Dose	Reason for use
....	....	....
....	....	....
....	....	....
....	....	....
....	....	....

Please indicate if you currently have, or have had, any of the following conditions

- ○ Cancer
- ○ Bladder Incontinence
- ○ Bowel Incontinence
- ○ Congestive Heart Failure
- ○ Degenerative Disk Disease
- ○ Depression
- ○ Digestive Issues
- ○ Epilepsy
- ○ Fibromyalgia
- ○ Hearing Loss
- ○ Heart Attack
- ○ Heart Diseases
- ○ Hepatitis
- ○ High Blood Pressure
- ○ HIV
- ○ Hot Flashes
- ○ Kidney Diseases
- ○ Low Blood Pressure
- ○ Osteoarthritis
- ○ Osteoporosis
- ○ Pacemaker
- ○ Respiratory Disease
- ○ Rheumatoid Arthritis
- ○ Skin Conditions
- ○ Stroke
- ○ Thyroid Disease
- ○ Tuberculosis
- ○ Vaginal Dryness
- ○ Varicose Veins
- ○ Vascular Disease
- ○ Other:

....

....

Please answer the following questions if you have, or had, a diagnosis of cancer.
If not, please proceed to the next section

Doctors	Name	Address
Surgeon	....	....
Medical Oncologist	....	....
Radiation Oncologist	....	....

Type of Cancer

.... Affected side ○ left ○ right

Did you have surgery for your cancer? ○ yes ○ no

If yes, date of surgery .... Type of surgery ....

Did you have lymph nodes removed? ○ yes ○ no

If yes, # removed .... # positive ....

Did you, or will you receive radiation treatments? ○ yes ○ no

If yes, # of treatments .... Start date ....

Did you or will you receive chemotherapy treatment? ○ yes ○ no

If yes, # of cycles .... Start date ....

Emergency Contact

Name

....

Relationship	**Phone Number**

I have read, understood, and have had the opportunity to discuss the clinic's:

- ○ Release of information form
- ○ Privacy policy
- ○ Fee and payment schedule
- ○ Cancellation policy

My signature below indicated my understanding of all the above information and polices listed above

....	....
Signature	Date [DD/MM/YYYY]