St. Joseph's Hospital
Breast Care Program, Room D1-112
268 Grosvenor St., P.O. Box 5777, Stn. B
London, ON N6A 4V2
Tel. 519-646-6000 ext. 65020

Patient History Form Instructions

The information you provide on the Patient History form will be used by the Breast Care Program surgeon and clinic staff to plan and carry out your care.

1. Please complete the Patient History form **at least 4 days before your appointment**

2. This form is set up to be completed electronically (on-line). Please make sure you have all of your information with you when you start to complete it.

3. To add your answers to the form:
    a. Add information to the text boxes or select check box answers for each question.
    b. When you have finished filling out the form, click the SUBMIT FORM button at the bottom of page 2 to submit the form to St. Joseph's Breast Care Program by e-mail. If the button does not link to your e-mail service, please e-mail the completed form to BreastCare@sjhc.london.on.ca .

    Please note: The email address used to send you the link to the form is used only to receive forms back; staff will not reply to e-mails about appointment or health information sent to that address.

    If you have any questions about completing the form, please call St. Joseph's Breast Care Program at 519 646-6100 ext. 65020.

    If you have questions about your Breast Care Program appointment, please call 519-646-6100 extension 65008.

For information about St. Joseph's privacy policy and use of electronic communications, please visit St Joseph's website at www.sjhc.london.on.ca/patientprivacy

Please complete and **submit at least 4 days** before your appointment

Breast Care Program - Patient History

Name: _____ Today's date: _____

Date of birth: _____ Weight: _____ KG / LB Height: _____ IN/CM
(dd/mmm/yyyy)

Referring doctor: _____ Health Card Number: _____

Please describe the reason you have been referred to the Breast Care Program:

1. Reproductive History

How old were you when you had your first period? _____

When did you have your last period? _____

Number of pregnancies? _____

Number of live births? _____

How old were you when you had your first baby? _____

Did you breastfeed? ☐ Yes ☐ No

If yes, for how long?

Have you ever taken hormones? ☐ Yes ☐ No

Are you taking them now? ☐ Yes ☐ No

Number of years?

Are you currently taking the birth control pill? ☐ Yes ☐ No

Have you ever taken the birth control pill? ☐ Yes ☐ No

Number of years taken?

When did you stop?

2. Lifestyle History

Do you *currently* smoke? ☐ Yes ☐ No

If yes, how many years? _____

How many cigarettes per day? _____

Have you *ever* smoked? ☐ Yes ☐ No

If yes, when did you stop? _____

How many cigarettes per day? _____

Alcohol use:

☐ Never

☐ Occasionally

☐ Daily - If daily, how many drinks? _____

3. Social History

Occupation? _____

Do you work outside your home? ☐ Yes ☐ No

Who provides emotional support to you?

Check all that apply

☐ Husband/wife ☐ Partner

☐ Parents ☐ Children

☐ Friends

4. Medical Problems

Please check the box if you *have or have had any* of these health problems:

☐ Diabetes ☐ Thyroid problems ☐ Bleeding problems ☐ High Blood Pressure ☐ Lung disease/Asthma

☐ Arthritis ☐ Heart Attack ☐ Previous cancer ☐ Anxiety/Depression

☐ Other (please explain): _____

5. Family History

Has anyone in your family had breast cancer or ovarian cancer?

Breast cancer? ☐ Yes ☐ No Ovarian cancer? ☐ Yes ☐ No

Relative: _____ Age at diagnosis: _____ Relative: _____ Age at diagnosis: _____

Relative: _____ Age at diagnosis: _____ Relative: _____ Age at diagnosis: _____

Are there any other cancers in your family? _____

6. Surgical History

Have you ever had surgery? ☐ Yes ☐ No

If yes, please list:

Date	Surgery

Have you ever had an anesthetic? ☐ Yes ☐ No

Did you have any problems with or reaction to the anesthetic? ☐ Yes ☐ No

If yes, please explain: _____

Do you have known allergies to…?		If yes, please list allergen(s) and the reaction(s):
…drugs or medications?	☐ Yes ☐ No	
…environmental allergens?	☐ Yes ☐ No	
…food?	☐ Yes ☐ No	

7. Medication List

List ALL of your medications, including prescription drugs, over-the-counter remedies/medications, herbals and vitamin/mineral supplements.

Medication name and strength	How many times per day do you take it?	Why are you taking this medication?

SUBMIT FORM