MEDICAL HISTORY

LEUKEMIA & LYMPHOMA SOCIETY OF CANADA®

WORKSHEET FOR CAREGIVERS

When visiting a doctor, especially if it is the first visit, it is helpful to prepare your loved one's medical history in advance. The members of the healthcare team need as much information as possible so that they can determine the best treatment plan. The doctor's office may have specific forms, but this worksheet will help you collect the basic information needed before the appointment.

Your loved one's information

NAME _____ DATE OF BIRTH (DOB) _____

PHONE NUMBER(S) _____

ADDRESS _____

EMAIL _____

EMPLOYER _____

SPOUSE'S NAME _____

SPOUSE'S PHONE NUMBER(S) _____

EMERGENCY CONTACT _____

EMERGENCY CONTACT'S PHONE NUMBER(S) _____

Primary care provider information

PRIMARY CARE PROVIDER _____

PRACTICE NAME _____

PHONE NUMBER(S) _____ FAX NUMBER _____

ADDRESS _____

EMAIL _____

Medical history

In the past, has your loved one been diagnosed with any of the following? Check all that apply.

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood clots (for example, thrombosis)
- ☐ Cancer
  Type: _____
- ☐ Colitis
- ☐ Concussion
- ☐ Depression
- ☐ Diabetes
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol level
- ☐ HIV/AIDS
- ☐ Impaired mobility
- ☐ Irritable bowel syndrome
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lung disease
- ☐ Migraines
- ☐ Sexually transmitted infections (STIs)
- ☐ Urinary tract infection
- ☐ Other:
  _____
  _____

List any previous surgeries, tests, hospitalizations or major procedures.

Procedure	Description/purpose	Date

Family medical history

Has anyone in your loved one's family experienced any of the following? If so, who?

Disease	Family member
Asthma	
Blood clots	
Cancer (list types)	
Depression	
Diabetes	
Heart disease	
Hepatitis	
High blood pressure	
High cholesterol level	
Low blood pressure	
Kidney disease	
Lung disease	
Irritable bowel syndrome	
Liver disease	
Colitis	
HIV/AIDS	
Other	

Medications and allergies

List all the medications your loved one is taking. Include any vitamins, supplements or over-the-counter medications.

Medication name	Dosage/frequency	Reason taken

List all allergies to medications, foods, and any other substances:

Pharmacy

PHARMACY NAME

PHONE NUMBER(S) FAX NUMBER

ADDRESS