Client No. _____

Quest Community Health Centre
Client Health History Form

The information requested on this form will help us to provide you with the best care as well as allow us to evaluate the services at Quest Community Health Centre (CHC). We would ask for your support in completing the following questions. Completing this form is voluntary (with the exception of your name). If you do not fill out all the questions, you can still access Quest CHC services, but missing information may affect our ability to provide comprehensive care. The information may be used in evaluation of Quest CHC services. No names or identifiers will be included during the evaluation process.

Date: _____

Legal Name (as shown on Health Card):

_____
First Name Middle Name(s) Last Name

Preferred Name:

_____
First Name Middle Name(s) Last Name

Are you filling this out for yourself? □ Yes □ No

If no, what is your relationship to the person? _____

MEDICAL HISTORY

Check off any of the following conditions that affect you or that you have experienced:

□ Asthma	□ High blood pressure	□ Diabetes
□ Epilepsy	□ High cholesterol	□ Kidney disease
□ Drug/substance abuse	□ Blood clots	□ Cancer
□ Alcohol abuse	□ Heart disease/stroke	□ Eczema

Others: _____

Do you use any medical devices? (e.g. cane, walker, glasses, hearing aids, dentures)? □ Yes □ No

Have you ever gone to an emergency room or been admitted to hospital? □ Yes □ No

Have you ever had an operation(s)? □ Yes □ No

Have you ever been in a serious accident(s) e.g. car accident, slip and fall? □ Yes □ No

EMOTIONAL HISTORY

Check off any of the following conditions that affect you or that you have experienced:

□ Abuse/violence	□ Gambling	□ Self-harm behaviour	□ Grief/death
□ Bullying	□ Legal issues	□ Suicidal thoughts/attempts	□ Feeling depressed
□ Anger issues	□ Difficulty learning	□ Extreme guilt or shame	□ Feeling anxious
□ Low self-esteem	□ Poor concentration	□ Severe mood swings	□ Disordered eating
□ Sexual assault	□ Hyperactivity	□ Hoarding	□ Stress
□ Physical assault	□ Poor impulse control	□ Poor memory	□ Panic/anxiety attacks
□ Verbal assault	□ Difficulty controlling emotions	□ Easily startled or hyper-vigilant	□ Flashbacks, night terrors or intrusive thoughts
□ Overly suspicious or paranoid	□ Difficulty maintaining relationships	□ Hearing voices or having hallucinations	□ Death by suicide of a family member or friend

Have you ever gone to or are going to counseling/therapy? □ Yes □ No

ALLERGIC REACTIONS

Do you have any allergies, sensitivities or intolerances? □ *Yes* □ No □ Don't know

IMMUNIZATIONS

Do you have an immunization record? □ Yes □ No □ Don't know

MEDICATIONS

Are you taking any "over the counter" or prescription medications (even if not prescribed to you)?

□ Yes □ No If yes, please list your medications:

_____

_____

_____

_____

_____

Are you currently taking any herbal or vitamin supplements? □ Yes □ No

What pharmacy/pharmacies do you use? _____

HABITS

Do you smoke or use tobacco products? □ Yes □ No, never □ No, but I used to

Do you drink alcohol? □ Yes □ No, never □ No, but I used to

Do you use any recreational or street drugs? □ Yes □ No, never □ No, but I used to

If you use/used drugs, which one(s)?

□ Marijuana (weed) □ Heroin □ Crystal meth
□ Cocaine/crack □ Ecstasy □ Narcotics
□ Opiates □ Benzodiazepines □ Other: _____

Do you drink caffeinated beverages (e.g. coffee, tea, cola or energy drinks)? □ Yes □ No

Do you exclude any foods from your diet? □ Yes □ No

SEXUAL HISTORY

Are you or have you been sexually active? □ Yes □ No

If yes, how old were you when you first had sex? _____

Have you ever been tested for a sexually transmitted infection (STI)? □ Yes □ No

If yes, what were the results? _____

Have you had a new sexual partner since your last STI test? □ Yes □ No

Are you currently using safe sex practices (e.g. condoms, dental dams)? □ Yes □ No

If yes, how often? □ Rarely □ Sometimes □ Every time

What is your method of birth control?

□ Birth control pills □ Condoms □ IUD □ Withdrawal
□ Injections □ NuvaRing □ Patch □ Cycle method
□ Morning after pill □ Sponge/diaphragm □ Sterilization □ Other:_____

Have you ever been pregnant? □ Yes □ No If yes, how many times? _____

What was/were the result(s) of the pregnancy/pregnancies? (check all that apply)

□ Abortion □ Miscarriage □ Stillbirth □ Premature baby (28 - 36 weeks old) □ Full term baby (after 37 weeks) □ Other

Do your children live with you? □ Yes □ No □ I don't have any children

Do you have any adopted children or are you a legal guardian? □ Yes □ No

FAMILY HEALTH HISTORY

Are you adopted? □ Yes □ No

Please note below if any of the following health conditions affect your biological family members:

Asthma	High blood pressure	Diabetes	Family violence
Epilepsy	High cholesterol	Kidney disease	Sexual abuse
Drug/substance abuse	Blood clots	Cancer	Emotional concerns
Trauma	Heart disease/stroke	Alcohol abuse	Mental health issues

Name	Year Born	Living or Deceased	Health Condition(s)
Parents:			
Children:			
Siblings:			
Grandparents/Others:			

When was your last health exam/physical? _____ □ Don't know

Client No. _____

The above is accurate to the best of my knowledge. I consent to treatment, and agree to participate in reaching my health care goals in partnership with Quest Community Health Centre.

_____ _____
Client Signature Date

_____ _____
Signature of Quest CHC Provider who reviewed Client History Date

For Internal Use Only:

Client Code: 09 or 01

Screening Guidelines:
____ Periodic Health Exam (every 2 years)
____ Pap (21-70 q 3 years unless abnormal)
____ Mammogram (50+ q 2 years)
____ Fecal Occult Blood Test (50+ q 2 years)
____ Bone Mineral Density (69+)
____ Abdominal ultrasound (males over 75 yrs)

Immunizations:
____Tetanus every 10 yrs
____Flu vaccine annually
____Pneumococcal (>65 or with chronic disease)
____Hep A (per Public Health guidelines)
____Hep B (per Public Health guidelines)

Diabetes Care:
____ Inter profess. Treatment plan
____ Foot Exam