



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:

- | | | |
|---|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Drug/substance abuse | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Heart disease/stroke | <input type="checkbox"/> 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:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Abuse/violence | <input type="checkbox"/> Gambling | <input type="checkbox"/> Self-harm behaviour | <input type="checkbox"/> Grief/death |
| <input type="checkbox"/> Bullying | <input type="checkbox"/> Legal issues | <input type="checkbox"/> Suicidal thoughts/attempts | <input type="checkbox"/> Feeling depressed |
| <input type="checkbox"/> Anger issues | <input type="checkbox"/> Difficulty learning | <input type="checkbox"/> Extreme guilt or shame | <input type="checkbox"/> Feeling anxious |
| <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Severe mood swings | <input type="checkbox"/> Disordered eating |
| <input type="checkbox"/> Sexual assault | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Hoarding | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Physical assault | <input type="checkbox"/> Poor impulse control | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Panic/anxiety attacks |
| <input type="checkbox"/> Verbal assault | <input type="checkbox"/> Difficulty controlling emotions | <input type="checkbox"/> Easily startled or hyper-vigilant | <input type="checkbox"/> Flashbacks, night terrors or intrusive thoughts |
| <input type="checkbox"/> Overly suspicious or paranoid | <input type="checkbox"/> Difficulty maintaining relationships | <input type="checkbox"/> Hearing voices or having hallucinations | <input type="checkbox"/> 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)?

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Marijuana (weed) | <input type="checkbox"/> Heroin | <input type="checkbox"/> Crystal meth |
| <input type="checkbox"/> Cocaine/crack | <input type="checkbox"/> Ecstasy | <input type="checkbox"/> Narcotics |
| <input type="checkbox"/> Opiates | <input type="checkbox"/> Benzodiazepines | <input type="checkbox"/> 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?

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Condoms | <input type="checkbox"/> IUD | <input type="checkbox"/> Withdrawal |
| <input type="checkbox"/> Injections | <input type="checkbox"/> NuvaRing | <input type="checkbox"/> Patch | <input type="checkbox"/> Cycle method |
| <input type="checkbox"/> Morning after pill | <input type="checkbox"/> Sponge/diaphragm | <input type="checkbox"/> Sterilization | <input type="checkbox"/> 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)

- | | | | | | |
|-----------------------------------|--------------------------------------|-------------------------------------|--|---|--------------------------------|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Stillbirth | <input type="checkbox"/> Premature baby
(28 - 36 weeks old) | <input type="checkbox"/> Full term baby
(after 37 weeks) | <input type="checkbox"/> 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

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