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/issues that you are or have experienced:

□ Auto-immune Disease/ Endocrine issues (eg. Lupus, Rheumatoid arthritis, diabetes, Hypothyroidism)
□ Blood disorders (eg. anemia, hemophilia)
□ Cancer
□ Cardiovascular issues (eg. high/low blood pressure, stroke, heart attack, chest pain irregular heartbeat)
□ Dermatological issues (eg. eczema, dermatitis, rosacea)
□ Gastrointestinal issues (eg. irritable bowel syndrome, reflux, hemorrhoids, liver disease, jaundice)
□ Genitourinary issues (eg. chronic kidney disease, urinary tract infections)
□ Respiratory issues (eg. asthma, COPD, pulmonary fibrosis)
□ Musculoskeletal issues (eg. arthritis, osteoporosis, gout,)
□ Neurological issues (eg. epilepsy, Parkinson's Disease, multiple sclerosis)
□ Psychiatric issues (eg. anxiety, depression, PTSD)
□ Sexually transmitted infections (eg. herpes/cold sores, syphilis, gonorrhea, chlamydia)
□ Viral infections (eg. HIV, Hepatitis)
□ Organ transplant

□ Surgery/Operations/Joint replacement (eg. Hysterectomy, tubal ligation, heart surgery, pacemaker, stents)
Please specify: _____
_____
_____

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

Have you ever gone to an emergency room or been admitted to hospital in the last 6 months?
□ 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 are or have experienced:

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

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

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
_____
_____
_____
_____

Client 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

PERSONAL HISTORY

What is your current marital status? Check ONLY one

□ Single	□ Married	□ Common- Law
□ Separated	□ Divorced	□ Widowed

Do you have any children (eg. biological, adopted, kinship)?
□ Yes □ No □ Unknown

If yes, please indicate how many children you have in each age range:
☐ 0-6 years ____
☐ 7-12 years ____
☐ 13-18 years ____
☐ 19+ years ____

If yes, are there any legal custody agreements?
_____
_____

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
□ Cocaine
□ Narcotics (eg. codeine, fentanyl, heroin, morphine, oxycodone)
□ Benzodiazepines (eg. clonazepam, diazepam, lorazepam)
□ Hallucinogens (eg. Ketamine, LDS, MDMA, PCP)
□ Other: _____

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

Are you physically active? □ Yes □ No

Describe your nutrition over the last month:

□ No problems
□ Minor concerns (i.e. sometimes misses meals, usually eats most of the recommended servings from each food group)
□ Moderate concerns (i.e. frequently misses meals, eats some of the recommended servings from each food group, occasionally has no servings from one of the food groups)
□ Inadequate (i.e. does not eat enough food, usually eats few of the recommended servings from each food group, frequently has no servings from one of the food groups)
□ Highly Inadequate (i.e. urgent concerns exist regarding malnutrition and/or starvation)
□ Unknown

Are you interested in discussing, modifying or eliminating any of the above habits (eg. substance use, physical activity, nutrition)? □ Yes □ No
If yes, specify: _____
_____

SEXUAL HISTORY

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

If yes, how old were you when you first were sexually active? _____

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

Have you ever used Pre-Exposure Prophylaxis (PrEP) for the prevention of HIV? □ 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

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FAMILY HEALTH HISTORY

Are you adopted? □ Yes □ No

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

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

Client No. _____

For Internal Use Only:

Client Code:
____Receives Ongoing Primary Care (01)
____Receives Primary Care Elsewhere (09)

Screening Guidelines:
____ Pap (21-69 q 3 yrs unless abnormal)
____ Mammogram (50- 74 q 2 yrs unless abnormal)
____ Fecal Immunochemical Test (50-74 q 2 yrs unless abnormal)
____ Abdominal ultrasound (males over 75 yrs)

Immunizations:
____Tetanus (every 10 yrs)
____Flu vaccine (annually)
____Pneumococcal Vaccine (>65 or younger with chronic disease)
____Hep A Vaccine (per Public Health guidelines)
____Hep B Vaccine (per Public Health guidelines)
____Shingles Vaccine (65-70)

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