



## Quest Community Health Centre Trans 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 answer 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
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### Preferred Name:

First Name	Middle Name(s)	Last Name
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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 (e.g. 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 been 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

Have you ever been diagnosed with a Blood Clot?

Yes  No

Have you ever been diagnosed with or have active cardiovascular disease?

Yes  No

Are you taking anticoagulants (blood thinners)? (eg dabigatran, rivaroxaban, apixaban, edoxaban and betrixaban)

Yes  No

Do you have a family history of blood clots?

Yes  No

## **EMOTIONAL HISTORY**

Check off any of the following conditions that you have experienced in the past 12 months:

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

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:

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

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**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

- |                                    |                                   |                                      |
|------------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Single    | <input type="checkbox"/> Married  | <input type="checkbox"/> Common- Law |
| <input type="checkbox"/> Separated | <input type="checkbox"/> Divorced | <input type="checkbox"/> 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?

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**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: \_\_\_\_\_

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## **SEXUAL HISTORY**

Are you or have you been sexually active?  Yes  No

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
- Injections
- Morning after pill
- Condoms
- NuvaRing
- Sponge/diaphragm
- IUD
- Patch
- Sterilization
- Withdrawal
- Cycle method
- Other: \_\_\_\_\_

Client No. \_\_\_\_\_

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

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.

\_\_\_\_\_

For Internal Use Only: Client Code:
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\_\_\_\_ Receives Ongoing Primary Care (01)  
\_\_\_\_ Receives Primary Care Elsewhere (09)

Screening Guidelines:  
Date Last Completed

\_\_\_\_ Cervical Cancer Screening/HPV (25-69 q 5 years unless abnormal)  
(If Pap was completed last, then HPV test should be done at 3-year mark)

\_\_\_\_ Mammogram (50-74 q 2 years)  
(Can be screened age 40-49 via self-referral)

\_\_\_\_ Colon Cancer Screening/ Fit Test (50-74 q 2 years)/ \*\*OHIP Required  
(with no first-degree relative (parent, sibling or child) who has been diagnosed with colorectal cancer)

Immunizations:  
Date Last Completed

\_\_\_\_ Tetanus every 10 yrs  
\_\_\_\_ Flu vaccine annually  
\_\_\_\_ Covid Vaccine (Number of doses: \_\_\_\_\_)  
\_\_\_\_ Pneumococcal-20 (>65 or <65 with High-Risk Criteria)  
\_\_\_\_ Pneumococcal-15 (>50 with High-Risk Criteria)  
\_\_\_\_ Hep A (High Risk Criteria)  
\_\_\_\_ Hep B (Grade 7-12, or High-Risk Criteria)  
\_\_\_\_ Shingles (65-70)