



GENERAL ASSESSMENT
CONFIDENTIAL HEALTH QUESTIONNAIRE

PLEASE FILL OUT PRIOR TO YOUR APPOINTMENT FOR A COMPLETE PHYSICAL

NAME _____ **Age** _____ **Date** _____

How do you identify your gender? _____

What was your assigned sex at birth (i.e. on your birth certificate) Female Male

Reason for Visit _____

IMMUNIZATIONS: (record to review is ideal)

When was your last Tetanus shot? _____

Have you been immunized for Hepatitis B? _____ Hepatitis A? _____

Have you had 2 immunizations for Measles, Mumps, Rubella (MMR)? _____

Have you been immunized for Meningitis? _____

Have you had Chickenpox? Yes () No () If no have you been immunized? Yes () No ()

Have you had the HPV Vaccine Series? Gardasil () Gardasil 9 () Cervarix () Have not had it ()

Answer only if applicable:

First day of your last menstrual period _____

How many Pap tests have you had? _____

Have they all been normal? _____ If no what was the problem? _____

Do you have any problems with your periods? _____

MEDICAL HISTORY:

Please list any ongoing medical problems (e.g. asthma, depression) _____

Please list any hospital admissions or surgery _____

List any allergies you have _____

List any medications you are taking (If birth control pill, which one?) _____

FAMILY HISTORY: Do any of your genetically related family members (parents, siblings, grandparents) have the following?

	Family member
Strokes at a young age (under 60)	
Clotting problems e.g. thrombophlebitis, pulmonary emboli	
High blood pressure	
Heart disease	
High cholesterol/Lipids or fat in the blood	
Diabetes	
Thyroid disease	
Migraine	
Asthma	
Cancer of breast, bowel or stomach, other	
Alcohol or drug issues	
Emotional or psychiatric	



LIFESTYLE:

If you're not from Canada, what countries have you lived in and when did you come to Canada?

Are you currently dating? Yes () No () _____

Do you have a sexual partner (s) Yes () No () _____

What types of sexual activity are you engaging in? (i.e. vaginal/frontal hole/anal/oral) _____

Do you use protection? (i.e. condoms, dental dam) always never sometimes

Who do you live with? _____

Do you have concerns about sexuality? Y/N _____

How long have you been with your current partner? _____

How many partners have you had in the last year? _____

Cigarette Smoking: Yes () No () # Cigarettes per day _____

Alcohol use: Yes () No () # Drinks per week _____

How often have you had 4 or more drinks in one night? _____

() Never () A few times/year () Once a month () Once a week () More than once a week

Street drug use: Yes () No () If yes which drugs and how often? _____

Have you or anyone else close to you ever felt that you should cut down on your alcohol or drug use? Yes/No _____

Exercise (list activities and frequency) _____

Diet: Do you eat all the food groups? _____

Do you follow a healthy diet? _____

Do you have any concerns about your sleep? _____

Academics: What program are you in? _____ What year? _____

Dental Care: When did you last see your Dentist/Hygienist? _____

Eye Care: When did you last have your eyes checked? _____

REVIEW OF SYSTEMS: Do you currently have any complaints about?

Headaches, eyes or vision _____

Ears, nose, or throat _____

Heart: chest pain, palpitations _____

Lungs or breathing _____

Stomach: pain, constipation, diarrhea _____

Back, muscles, or joints _____

Appetite: _____ Weight Concerns: _____

Mental health: Are you prone to depression () or anxiety ()

Do you have any other concerns?