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?