



The Periodic Health Visit is a wellness exam

- For patient that **DO NOT** have particular health concerns
- It includes: review of health history, lifestyle & risk factors, **limited** physical exam

PLEASE FILL OUT PRIOR TO YOUR APPOINTMENT

NAME _____ Age _____ Date _____
(MM/DD/YYYY)

How do you identify your gender? _____

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

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? _____

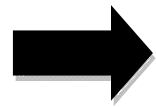
MEDICAL HISTORY:

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, grand parents) 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?

Who do you live with? _____

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

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? _____

Do you use condoms? Always/Never/Sometimes

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? _____