UNIVERSITY OF TORONTO

HEALTH & WELLNESS CENTRE
PERIODIC HEALTH VISIT FORM

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? _____