West Elgin Community Health Centre

Adult History Form Applicant Name: _____

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. Please fill in all pages. If you cannot remember specific details, please provide your best guess. Thank you!

IMMUNIZATIONS: Check off any vaccinations you have had. Add year, if known.

Tetanus (Td) _____ With Pertussis(Tdap) _____

Pneumovax (pneumonia) _____

Hepatitis A _____

MMR _____

Meningitis _____

Influenza (flu shot) _____

Varicella (Chicken Pox) shot *or* illness _____

Hepatitis B _____

Zostavax (shingles) _____

HPV _____

MEDICATIONS: Please list all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room.

☐ **I DO NOT TAKE ANY MEDICATIONS**

Medication	Dose (e.g. mg/pill)	How many times per day?

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Please list below all allergies or intolerances to medications, food, environment. ☐ **No Known Allergies**

Allergen	**Type of Reaction**
_____	_____
_____	_____
_____	_____

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol)	Date_____	Abnormal?	No	Yes
Sigmoidoscopy or Colonoscopy (circle one)	Date_____	Polyp?	No	Yes
Fecal Occult blood Test	Date_____	Abnormal?	No	Yes
Women only:				
Mammogram	Date_____	Abnormal?	No	Yes
Pap Smear	Date_____	Abnormal?	No	Yes
Bone Density Test	Date_____	Abnormal?	No	Yes

PERSONAL MEDICAL HISTORY:

Do you have now (current) or have you had (past) any of the following conditions? ☐ **NONE**

Condition	Current	Past	Comments
Alcohol/Drug abuse			
Allergy (Hay Fever)			
Anemia			
Anxiety			
Arthritis			
Asthma			
Bladder/Kidney Problems			
Blood Clot (leg)			
Breast Lump (Benign)			
Cancer Breast			
Cancer Colon			
Cancer Other Type			
Cataracts			
Chicken Pox/Shingles			

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Condition	Current	Past	Comments
Coronary Artery Disease			
Depression			
Diabetes			
Diverticulosis			
Emphysema/COPD			
Fractures (broken bones) Please list			
Gallbladder Disease			
Gastroesophageal Reflux (Heartburn/GERD)			
Glaucoma			
Gout			
Gynecological Conditions			
Heart Attack			
Hepatitis			
High Blood Pressure			
High Cholesterol			
Hip Fracture			
Irritable Bowel Syndrome			
Kidney Disease / Failure			
Kidney Stones			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pregnancy			
Prostate			
Seizures / Epilepsy			
Skin Conditions			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid			
Other (list)			

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SURGICAL HISTORY

Please check off any procedure or surgeries. List any abnormal finding or complications ☐ **NONE**

Surgical Procedure	Yes	Year	Comments
Abdominal Surgery			
Appendectomy (appendix removal)			
Back Surgery			
Biopsy (location)			
Breast Surgery			Circle: Right Left Both
Colonoscopy			
Coronary Bypass			
Coronary Stent			
Stomach Endoscopy			
Cataract			
Gallbladder Removal			Circle: Laparoscopic
Heart Surgery (other than bypass)			
Hip Surgery			Circle: Right Left Both
Hysterectomy			Circle: Laparoscopic Vaginal Abdominal
Knee Surgery			Circle: Right Left Both
LEEP (Cervix Surgery)			
Neck Surgery			
Ovary Ligation (“Tubal”)			
Ovary Removal			Circle: Right Left Both
Vasectomy			
Sigmoidscopy			
Sinus Surgery			
Other (list)			

WOMEN’S HEALTH HISTORY:

Total number of pregnancies: _____ Number of births: _____

Date (month/day if known) of last menstrual period if you are still menstruating: _____

Are you pregnant? ☐ No ☐ Yes Who is monitoring your pregnancy _____

Age at beginning of periods (menstruation): _____ Age at end of periods (menopause): _____

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FAMILY HISTORY – Indicate which relative has had the following diseases

	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative	Comments
Alcoholism/Drug abuse										
Alzheimers										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer - Breast										
Cancer - Colon										
Cancer - Other Type										
Cancer - Ovarian										
Cancer - Prostate										
Colon - Polyp										
Coronary Artery Disease (e.g. heart attack, angina)										
Depression/ Suicide/ Anxiety										
Diabetes (childhood onset)										
Diabetes (adult onset)										
Emphysema (COPD)										
Genetic Disorder (explain)										
Glaucoma										
Heart Disease (CHF)										
Heart Disease (Other)										
Hepatitis B or C										
High Blood Pressure - Hypertension										
High Cholesterol										
Hip Fracture										
Hypothyroidism/Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Migraine Headaches										
Osteoporosis										
Other										

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OTHER HEALTH ISSUES:

Tobacco Use: Have you ever smoked cigarettes: ☐ No ☐ Yes Still smoking? ☐ No ☐ Yes If you smoked and quit, list quit date: _____ How many years did/have you smoked: _____ If quit, # packs/day did you smoke: _____ Current Smoker: Packs/day _____	**Exercise:** Do you exercise regularly? ☐ No ☐ Yes What kind of exercise? _____ _____ _____ How long do you exercise (minutes) _____ How Often? _____
Alcohol Use: Do you drink alcohol? ☐ No ☐ Yes # of drinks/week _____ Beer Wine Liquor	**Diet:** How would you rate your nutrition/diet? Good Fair Poor Would you like advice on your diet? ☐ No ☐ Yes
Drug Use: Do you use marijuana/recreational drugs: ☐ No ☐ Yes Have you ever used needles to inject drugs: ☐ No ☐ Yes Current use: _____	

OTHER SUPPORTS:

Are you currently seeing any other specialist/service/counselor? State name/why seeing/when last seen

Who: _____ When Last seen: _____

WHY _____

Are you currently seeing any other specialist/service/counselor? State name/why seeing/when last seen

Who: _____ When Last seen: _____

WHY _____

Are you currently seeing any other specialist/service/counselor? State name/why seeing/when last seen

Who: _____ When Last seen: _____

WHY _____

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SOCIAL HISTORY, GOALS AND SUPPORTS:

This information helps us to better understand who you are, your strengths and your support systems. It will also help to identify your beliefs, values and cultural preferences so that we can incorporate them into your care where Possible.

Highest level of education completed: _____

Circle one: Working Retired Unemployed Leave of absence Disabled Other

Occupation (or prior occupation): _____

Employer: _____

Marital status (circle one): Single Partner Married Divorced Widowed

Spouse/partner's name: _____

Number of children: _____ Ages if under 18 years: _____ Number of grandchildren: _____

Do you live alone? _____ If not alone, who lives with you? _____

Do you have access to transportation for appointments/programs/personal needs? _____

State any specific transportation requests/needs: _____

Do you have access to sufficient funds/benefits to cover costs of medications/treatments? ☐ NO ☐ YES

If no, please explain: _____

Are you receiving ODSP/Ontario Works or other form of financial support to assist you? ☐ NO ☐ YES

Please list: _____

Please identify any cultural/religious preferences/needs that you would like us to know about so we can incorporate them into your care:

_____

_____

_____

Please list any specific goals you would like to work on with your care team:

_____

_____

_____

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If you have legally appointed a Power of Attorney for Personal Care (PAPC) to make health care decisions on your behalf if you became unable to do so, please list their contact information below. If you do not have a PAPC, the law lists who the person would be in order of position (e.g. spouse, parent, child, sibling etc.).

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

If you have a written Advanced Care Plan, please provide us with a copy for your file.

We know that having conversations about your care wishes can often be difficult. To help to ensure that decisions made on your behalf are in keeping with your beliefs and values, we suggest that everyone, no matter your age or health status, talk about your wishes with your family/substitute decisions makers.

Please list below, anything else you feel it would be helpful for us to know.

_____

_____

_____

_____

The information on this form will be used to build your chart. It is also used to help us divide applicants among our providers so each provider has similar numbers of complex clients to care for.

We invite all applicants for an intake appointment. At this appointment, we share what the centre offers, review the application and discuss client care needs and expectations. At the end of the intake, if you decide you wish to be a client with us, we will have you sign some forms regarding your privacy etc.

The intake appointment is a meet and greet. We will not be completing forms, writing prescriptions etc. at this appointment.

Thank-you for taking the time to fill this out