ÉQUIPE DE SANTÉ FAMILIALE
Bilan de santé préventif

ByWard

FAMILY HEALTH TEAM
Preventive Health Assessment

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The purpose of the Preventive Health Assessment is to perform a customized review of each individual patient's health situation. This includes: reviewing your present health, past health history, and family history; ensuring that important preventive health measures, such as pap smears and immunizations, are up-to-date; and providing an opportunity for us to discuss new preventive health recommendations that may apply to your individual situation.

Please note that the information submitted on this form will only be reviewed with your primary care provider at your first visit.

A Patient Information

Name _____ Birth Date _____ Health Card # _____ Phone # _____

Address: *Street/Apt.* _____ *City* _____ *Prov.* _____ *Post. Code* _____

B Personal and Social History

1. ☐ Single ☐ Married ☐ Couple ☐ Common-law ☐ Separated ☐ Divorced ☐ Re-married ☐ Widowed

2. Household >>
☐ Live alone ☐ Partner ☐ With (#) ___ Children ☐ Other family members ☐ Roommates

3. ☐ Student Current employment: _____ Previous employment: _____ ☐ Unemployed ☐ Retired

4. Highest level of education: _____ **5.** Lived mostly in which country: _____ **6.** Ethnicity: _____

C Medications

☐ Current Medication With Prescription _____
☐ Current Medication Without Prescription _____
☐ Vitamins, Herbal Products _____

D Allergies

Do you have any allergies? If yes, specify:
☐ Medications _____ ☐ Environmental _____
☐ Food _____ ☐ Latex _____

E ☐ *No change from previous* Past Medical History

a. Have you ***ever had*** or do you now have any significant disease of:	**No**	**Yes**	**Specify**
1. Eyes, Ears, Nose or Throat e.g. tonsils, deafness, hay fever, visual problems etc.	☐	☐	
2. Respiratory System e.g. chronic cough, asthma, tuberculosis, pneumonia, etc.	☐	☐	
3. Cardiovascular System e.g. rheumatic fever, heart attack, phlebitis, angina, etc.	☐	☐	
4. Digestive System e.g. ulcer, colitis, jaundice, gallbladder disease etc.	☐	☐	
5. Genito-Urinary System e.g. kidney or bladder trouble, stones, etc.	☐	☐	
6. Musculo-Skeletal System e.g. Arthritis, Fractures, etc.	☐	☐	
7. Skin, Lymph Glands, Cyst, Tumour or Cancer	☐	☐	

Past Medical History (cont.)

8. Reproductive System
e.g. major gynaecological problem, obstetrical problem, prostate, testicle etc.
First Day of Last Menstruation (Date): _____

9. Endocrine System
e.g. Diabetes, Thyroid Gland, etc.

10. Nervous System
e.g. Migraines, Epilepsy, Paralysis, etc.

11. Emotional Health/Mental Health
e.g. depression, anxiety, anorexia, bulimia, suicide attempt, physical, emotional or sexual abuse, cognitive decline, etc.

12. Contagious Diseases
e.g. hepatitis B, tuberculosis, STI, HIV, etc.

13. Other (Specify)

b. Have you ever had surgery, injury or illness requiring hospitalization?

F Family History

	Heart Disease/Stroke	High Blood Pressure	High Cholesterol	Diabetes	Mental Illness	Cancer	Other (Tb, congenital disease, asthma, neurological, osteoporosis, glaucoma, etc.)
Mother	☐	☐	☐	☐	☐	☐ Type: _____ Age at Diagnosis: _____	☐ _____
Father	☐	☐	☐	☐	☐	☐ Type: _____ Age at Diagnosis: _____	☐ _____
Brothers	☐	☐	☐	☐	☐	☐ Type: _____ Age at Diagnosis: _____	☐ _____
Sisters	☐	☐	☐	☐	☐	☐ Type: _____ Age at Diagnosis: _____	☐ _____
Children	☐	☐	☐	☐	☐	☐ Type: _____ Age at Diagnosis: _____	☐ _____

G Lifestyle

1. Do you have a history of smoking? ☐ No ☐ Yes >> Quantity & Frequency: _____
Have you used any form of tobacco in the last 7 days? ☐ No ☐ Yes >> Quantity & Frequency: _____
Have you used any form of tobacco in the last 6 months? ☐ No ☐ Yes >> Quantity & Frequency: _____

2. Do you use alcohol? ☐ No ☐ Yes >> Quantity: _____ >> Frequency: _____

3. Do you use recreational drugs ☐ No ☐ Yes >> Type: _____ >> Frequency: _____

4. Do you consume caffeine? ☐ No ☐ Yes >> Quantity: _____ >> Frequency: _____

5. Do you exercise? ☐ No ☐ Yes >> Type: _____ >> Frequency: _____

6. Do you have any dietary restrictions? _____

7. When was your last dental exam? _____ When was your last eye exam? _____

8. Sun safety. Do you wear sunglasses? ☐ No ☐ Yes Do use sunscreen daily with a minimum of spf 30? ☐ No ☐ Yes Do use tanning beds? ☐ No ☐ Yes

I Menstrual History

1. At what age did you start menstruating? _____ **2.** Number of Pregnancies: _____ **3.** Number of Miscarriages: _____ **4.** Number of Therapeutic Abortions: _____

5. Menopause ☐ >> Age at last menstrual period: _____

J Sexual History

1. Sexual Partners ☐ Men ☐ Women ☐ Both **2.** Are you sexually active? ☐ Now ☐ In the past

3. Contraception ☐ None ☐ Pill ☐ Condom ☐ Other >> _____

4. Number of sexual partners in the past 60 days _____ **5.** Number of sexual partners, in the past 12 months _____ **6.** Have you ever had an abnormal "PAP" ☐ No ☐ Yes

7. History of sexual abuse ☐ No ☐ Yes **8.** History of sexually transmitted infections ☐ No ☐ Yes **>>** Specify _____

K New Health Problems

As noted on the previous page, today's visit is focused on prevention. As such, we may not have time to address all of your new health concerns.

Do you have *new* problems with:	No	Yes	Details or Other Problems
1. Eyes, Ears, Nose or Throat?	☐	☐	
2. Respiratory System? e.g. chronic cough, difficulty breathing, asthma, frequent bronchitis	☐	☐	
3. Cardiovascular System? e.g. chest pain, swelling of ankles, shortness of breath	☐	☐	
4. Digestive System? e.g. change in bowel pattern	☐	☐	
5. Genito-Urinary System? e.g. frequent urination, pain on voiding, voiding at night, difficulty voiding, incontinence	☐	☐	
6. Gynecological or Obstetrical Problems? e.g. painful menses, irregular, heavy flow	☐	☐	
7. Musculo-Skeletal System? e.g. joint pain, back pain	☐	☐	
8. Breasts? e.g. pain, lumps, discharge	☐	☐	
9. Endocrine System? e.g. *recent* weight loss	☐	☐	
10. Nervous System? e.g. migraines, epilepsy, paralysis	☐	☐	
11. Emotional Health? e.g. depression, anxiety	☐	☐	
12. Dermatological? e.g. new or changing moles, history of severe sunburns, rashes	☐	☐	

_____ _____ _____ _____

Patient Signature *Date* *Provider Signature* *Date*