Mount Forest Family Health Team

Claire Stewart Medical Clinic

525 Dublin Street, Mount Forest ON N0G 2L3
Tel: 519.323-0255 **Fax:** 519.323-2113

HEALTH HISTORY FORM

STAMP

PATIENT INFORMATION		DATE:			
LAST NAME:		FIRST NAME:		MIDDLE NAME:	
ADDRESS:		CITY & POSTAL:			
BIRTH DATE:		GENDER:	MALE ☐ FEMALE ☐		
PHONE (H):		PHONE (W):		PHONE (OTHER):	
HEALTH CARD #:		OCCUPATION/EMPLOYER:			
PARENT/GUARDIAN (IF UNDER 16):	NAME:			RELATIONSHIP:	
PHONE NUMBER:		CONTACT INFO. THE SAME:	YES ☐ NO ☐		

MEDICATION INFORMATION - Please list all medication, vitamins you are currently taking.

Medication:

Vitamins/Minerals:

FAMILY HISTORY – Please check all that apply and indicate which relative the number pertains to

1. Epilepsy
2. Migraine
3. Mental illness
4. Glaucoma
5. Diabetes
6. Thyroid disease
7. Hay Fever
8. Asthma
9. Anemia
10. Osteoporosis
11. Arthritis
12. Heart Disease
13. Stroke
14. Hypertension
15. Lipid Disorder
16. Alcoholism/Drug Abuse
17. Hepatitis
18. Cancer
19. Cholesterol
20. _____
21. _____

HOSPITAL ADMISSIONS - please provide a listing of your hospital admissions (not including pregnancies)

ILLNESS OR OPERATION		YEAR	

MEDICAL HISTORY – present or past history, please check all that apply

- ☐ Abdominal Pain/Chronic
- ☐ ADHD
- ☐ Aids/Hiv
- ☐ Alcohol Abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Problems
- ☐ Bronchitis/Chronic Cough
- ☐ Cancer _____
- ☐ Chest Pain
- ☐ Chronic Fatigue
- ☐ Constipation
- ☐ Chrohn's/Colitis
- ☐ Depression
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Disability/Handicap
- ☐ Diverticulosis
- ☐ Drug Abuse
- ☐ Ear Trouble/Hearing
- ☐ Eating Disorder
- ☐ Eczema
- ☐ Eye Disease/Problems
- ☐ Fainting Spells
- ☐ Gallbladder Trouble
- ☐ Gout
- ☐ Head Injury
- ☐ Headache (Recurrent)
- ☐ Heartburn
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hemorrhoids
- ☐ Hepatitis/Jaundice
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ Intestinal/Stomach Trouble
- ☐ Joint Disease/Injury
- ☐ Menstrual Problems
- ☐ Mental Illness
- ☐ Migraine Headache
- ☐ Nausea/Vomiting
- ☐ Numbness
- ☐ Osteoporosis
- ☐ Palpitations
- ☐ Pneumonia
- ☐ Psychological Counseling
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Infections
- ☐ Seizures
- ☐ Stroke
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Trouble
- ☐ Sleep Problems
- ☐ Suicidal Thoughts
- ☐ Swollen Ankles
- ☐ Throat/Swallowing Problems
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Urinary Tract Infection
- ☐ Urination – Overactive
- ☐ Urination - Incontinence
- ☐ Ulcer - Peptic
- ☐ Varicose Veins/Phlebitis
- ☐ Weight Loss/ Gain
- ☐ alcohol _____ ox. per week
- ☐ Coffee/Tea _____ cups per day
- ☐ _____
- ☐ _____

☐ Smoking _____ cig/day
☐ Smoking _____ number of years
☐ Exercise _____ times per week

Females: Please complete

Menstrual Flow:
☐ Reg. ☐ Irreg. ☐ Pain/Cramps
Days of flow _____
Length of cycle _____
Date – 1st day of last period _____
☐ Pain/Bleeding during or after sex

Number of:
Pregnancies _____ Abortions _____
Miscarriages _____ Live Births _____

Birth control method: _____
Birth control name: _____
☐ Flushing/Menopause
Date of last PAP Test: _____
☐ Normal ☐ Abnormal
Date of last mammogram: _____
☐ Normal ☐ Abnormal

HEALTH HISTORY FORM
Page 2

ALLERGY INFORMATION – Please list all allergies e.g. penicillin, peanuts, etc.	
Drug Allergies:	
All Other Allergies:	

1. Do you presently have a health care provider (Physician or Nurse Practitioner)?

YES ☐ ☐ Physician: _____ Date of last visit: _____

☐ Nurse Practitioner: _____ Date of last visit: _____

☐ Chiropractor: _____ Date of last visit: _____

☐ Other: _____ Date of last visit: _____

NO ☐ Date of your last visit to a Physician or Nurse Practitioner? _____

2. When was the last time you had a general physical?

_____

_____

3. Why do you wish to see a Physician or Nurse Practitioner? Are there any question you would like to ask?

_____

_____

_____

I verify that the information provided on this form is complete and accurate to the best of my knowledge.	
Signature:	Date:

The information on this form is collected under the regulations of the Personal Health Information Protection Act. The Mount Forest Family Health Team is required to take reasonable steps to ensure the confidentiality of the personal health information we receive from you. For more information about our practices, please contact the Privacy Officer, Mount Forest Family Health Team, 525 Dublin St., Mount Forest, ON N0G 2L3, 519.323.0255 extension 5004.

OFFICE USE

Form Reviewed By: _____ Date Reviewed: _____

Name of Primary Care Provider: _____ Rostering Physician: _____

Letter and Roster Form Mailed: ☐ Yes: _____ (date) File Set up In Computer: _____ (date)