HEATH SUMMARY FORM

FULL NAME: _____ DOB: _____

This information is used by the healthcare staff to provide you with quality healthcare. It is entirely confidential.

Do you currently have or previously had any of the following:	
Asthma	☐Yes ☐No
Diabetes	☐Yes ☐No
High blood pressure	☐Yes ☐No
Heart disease	☐Yes ☐No
Mental health conditions	☐Yes ☐No
Thyroid conditions	☐Yes ☐No
Any other health conditions:	☐Yes ☐No
If yes to any of the above, please provide details:	

Please list current medication/s (including nonprescription):

Have you ever had any operations? If yes, please list:

Do any of your family members currently have or have had any of the following:	
Diabetes?	☐Yes ☐No
High cholesterol?	☐Yes ☐No
Cancer of breast, ovary, prostate or bowel	☐Yes ☐No
Heart attack, high blood pressure or stroke at <65 years of age?	☐Yes ☐No
If yes to any, please specify the relative and the condition/s:	

Have you had all of your childhood vaccines?	☐Yes ☐No
Have you had the HPV/Gardasil vaccines? *series of 2 shots (school) or 3 shots (other)*	☐Yes ☐No

Who are you currently living with? Where does your family or closest support live?

Do you have any allergies?	☐Yes ☐No
If yes, please list your allergen/s and the reaction/s	

What is your height in cm?	
What is weight in kg?	

Do you smoke?		☐Yes ☐No
If yes	How many cigarettes/day?	
	Are you interested in quitting?	☐Yes ☐No

Are you an ex-smoker?		☐Yes ☐No
If yes	When did you stop?	
	How many cigarettes did you smoke/day?	

Do you drink alcohol?		☐Yes ☐No
If yes	How many drinks per week?	

Have you ever had sex?	☐Yes ☐No
If yes, what are the gender/s of your partner/s?	

Do you use contraception?	☐Yes ☐No ☐N/A
If yes, what kind do you use?	
Do you use contraception every time you have sex?	☐Yes ☐No ☐N/A

Were you born with a variation of sex characteristics? (Sometimes called "intersex" or "differences/disorders of sex development")	☐Yes ☐No ☐Unsure ☐Prefer not to say

Have you ever had a PAP smear/Cervical Screen Test?		☐Yes ☐No ☐N/A ☐Unsure
If yes	When was your last one?	
	Were the results normal?	☐Yes ☐No

If you are over the age of 50:		
Have you ever had a prostate exam?		☐Yes ☐No ☐N/A ☐Unsure
If yes	When was you last one?	
	Were the results normal?	☐Yes ☐No
Have you ever had a breast x-ray or mammogram?		☐Yes ☐No ☐N/A ☐Unsure
If yes	When was your last one?	
	Were the results normal?	☐Yes ☐No

Have you had any recent life changing events? e.g. Death of a loved one, relationship breakup, moved to a new area?