Southside Family Health Centre

CENTRAL HEALTH *medical practice*

DR LUCY LORD • DR RULIN FUONG • DR SARAH BORWEIN

Island Health Family Practice

Health Screen Questionaire - WOMEN

Name: ______________________ Date of Birth: ______________________

Occupation: ______________________ Marital Status: ______________________

Date: ______________________ Doctor: ______________________

Current Health

Is there any special reason you have decided to have this medical? ______________________

____

Have you seen any GP's, Specialists or health professionals in the last 6 months? Yes ☐ No ☐

Reason: ______________________

Do you currently, or have you recently suffered from any of the following?

	Yes		Yes		Yes
Shortness of breath	☐	Dizziness	☐	Skin problems	☐
Wheezing	☐	Hearing problems	☐	Joint pain	☐
Coughing	☐	Visual changes	☐	Back pain	☐
Palpitations	☐	Indigestion	☐	Weight changes	☐
Chest pain	☐	Diarrhoea	☐	Sexual problems	☐
Poor circulation	☐	Constipation	☐	Insomnia	☐
Headaches	☐	Rectal bleeding	☐	Fever	☐
Fits/convulsions	☐	Urinary problems	☐		

Allergies

Do you have any allergies? ______________________

Do you protect yourself from the sun (hats/clothing)? Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never ☐

Do you use sunscreen creams? Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never ☐

Smoking

Do you: Currently smoke ☐ Wish to quit smoking ☐ Quit smoking ☐ (when?) ______ Never smoked ☐

Alcohol

How often do you drink?

Every day ☐ Most days ☐ Once or twice per week ☐ Weekdays only ☐ Special occasions ☐ Never ☐

Has your alcohol consumption increased over the last year? Yes ☐ No ☐

Do you ever feel you should cut down your drinking? Yes ☐ No ☐

Have you ever taken recreational drugs? Yes ☐ No ☐

Exercise

How often do you exercise? (days per week) ________

Nutrition

	Yes	No
Do you eat 3 meals a day?	☐	☐
Do you eat dairy produce most days?	☐	☐
Without wanting to, have you gained or lost more than 3 kilos in the last 6 months?	☐	☐
Do you eat fruit or vegetables most days?	☐	☐
Do you have 6-8 cups of fluids most days?	☐	☐
Are you on any 'special' diet (ie. lactose or gluten free / vegan / halal)?	☐	☐

Mood/Sleep

During the last 4 weeks how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, downhearted or blue?

Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely ☐

Do you feel that you have someone to talk to or support you if needed? Yes ☐ No ☐ Unsure ☐

Medication

Please list any medications taken (including vitamins, supplements, traditional chinese medicine) during the past 6 months:

____

____

Vaccination Record

Please tick vaccinations received;	Yes	No
Tetanus	☐	☐
Diphtheria and Pertussis	☐	☐
Hepatitis A	☐	☐
Hepatitis B	☐	☐
Measles-Mumps-Rubella (MMR)	☐	☐
Varicella	☐	☐
Polio (please list if received booster)	☐	☐

____

Travel + Specific

	Yes	No
HPV vaccine	☐	☐
Influenza	☐	☐
Typhoid	☐	☐
Rabies	☐	☐
Japanese Encephalitis	☐	☐
Meningococcal	☐	☐
Yellow Fever	☐	☐

Others (please list) ____

____

____

Current Health continued...

Women's Health

Question	Yes	No	
Have you had a PAP smear in the past 2 years?	☐	☐	
Was the result normal?	☐	☐	If no, please explain: ______
Have you had a mammogram in the past 2 years?	☐	☐	
Was the result normal?	☐	☐	If no, please explain: ______

What age did you have your first menstrual period? ______

What was the first date of your last menstrual period? ______

How many days from day 1 of one period to the next? ______

How many days do you normally bleed? ______

Question	Yes	No	
Are your periods regular?	☐	☐	
Are your periods painful or heavy?	☐	☐	Please explain: ______
Is there spotting between periods or the menopause?	☐	☐	
Do you have any vaginal discharge?	☐	☐	
Are you sexually active?	☐	☐	
Is intercourse painful?	☐	☐	
Do you bleed during intercourse?	☐	☐	
Have you had any sexually transmitted diseases?	☐	☐	Please explain: ______
Do you use contraception?	☐	☐	Please explain: ______
Do you have children?	☐	☐	If so, how many? ______
Did you have antenatal problems?	☐	☐	If so, what? ______

What type of delivery did you have? ______

Question	Yes	No
Have you experienced problems conceiving?	☐	☐
If so, have you had treatment for infertility?	☐	☐
Do you ever experience incontinence?	☐	☐
Is this related to coughing or sneezing?	☐	☐

Past Medical History

Have you ever suffered from any of the following? Please tick and write age of onset:

	Yes	Age		Yes	Age		Yes	Age
High blood pressure	☐	______	Diabetes	☐	______	Epilepsy	☐	______
High cholesterol	☐	______	Thyroid disease	☐	______	Cystitis	☐	______
Stroke	☐	______	Bronchitis	☐	______	Hernia	☐	______
Heart Attack	☐	______	Hayfever	☐	______	Kidney stones	☐	______
Angina	☐	______	Tuberculosis	☐	______	Gall stones	☐	______

Past Medical History continued...

	Yes	Age		Yes	Age		Yes	Age
Rheumatic fever	☐	______	Anaemia	☐	______	Depression	☐	______
Stomach ulcer	☐	______	Eye disease	☐	______	Anxiety	☐	______
Stomach problems	☐	______	Malaria	☐	______	Skin disease	☐	______
Asthma	☐	______	Back pain	☐	______	Hepatitis	☐	______

Please list any other significant illnesses: ____________________

____

Please list any operations/hospitalizations or accidents: ____________________

____

Please list anything else which concerns you about your health: ____________________

____

Family Medical History

	Yes	No	
Is your biologial father alive?	☐	☐	If so, how old is he? ____________
Does he have any health problems?	☐	☐	Please explain; ____________
If deceased, what was the cause of his death?			____________
Is your biological mother alive?	☐	☐	If so, how old is she? ____________
Does she have any health problems?	☐	☐	Please explain; ____________
If deceased, what was the cause of her death?			____________
Are your siblings alive?	☐	☐	
Have they suffered from any significant illnesses?			____________

Is there any family history of:

	Yes	No		Yes	No
High blood pressure	☐	☐	Epilepsy	☐	☐
High cholesterol	☐	☐	Cancer	☐	☐
Diabetes	☐	☐	Thyroid disease	☐	☐
Heart attack / heart disease	☐	☐	Depression / anxiety	☐	☐
Stroke	☐	☐	Glaucoma	☐	☐

Is there anything that runs in your family that you are concerned about? ____________________

____

____

____