CAMPUS HEALTH CENTRE

INITIAL INTERVIEW HISTORY FORM

(Please Print)

Date:______________________________

Name:____________________ **Birth Date:** _______/_________/________ **Age:**_____ **Sex: M F**

Year Month Day

Student: UOIT Durham Trent

Marital Status: Single Married Other______________________

How did you find out about this clinic? Friend School Doctor Advertisements Other_______

PERSONAL AND FAMILY HEALTH HISTORY- Check any health condition below that has been a problem for you and your family (mother, father, brother, sister, aunts, uncles, grandparents, etc.)

Allergies: Drugs__________________________________ **Other**___________________________________

	SELF	**FAMILY**		**SELF**	**FAMILY**
Headaches (Migraine)			Epilepsy		
High Blood Pressure			Depression		
Asthma			Anxiety		
Thyroid Condition			Hepatitis		
Kidney Disorder			Blood Clots		
Breast Cancer			Heart Attack		
Cervical Cancer			Diabetes		
Liver Disorder					
Tuberculosis			Other:_____________________________________		

Do you take prescribed medications regularly? No Yes ____________________________________
(List Medication)

Do you take herbal supplements/ home remedies? No Yes ____________________________________
(List)

Do you smoke? No Yes ____________________________________
(Packs per day)

Do you use street drugs? No Yes ____________________________________
(List Drugs)

Do you drink alcohol? No Yes ____________________________________
(Drinks per week)

How do you rate your eating habits? Good Fair Poor

STUDENTS ONLY:

STI/ BARRIER METHODS/ SEXUAL HEALTH/ CONTRACEPTION: Check any health condition below that has been a problem for you and/or your partner(s):

PRESENT PROBLEM(S):

Vaginal, penile or anal discharge ______________________
Burning during urination (peeing) ______________________
Itching or discomfort in genital area ______________________
Bumps or sores in genital area ______________________
Discomfort during sexual activity ______________________
Other ______________________

SAFER SEX HISTORY:

Have you ever been sexually active? No Yes
How old were you when you became sexually active? ____________
Did you use barrier methods and/or birth control the first time? No Yes

Are you using barrier methods and/ or birth control methods now? No Yes
If yes, check all methods that apply:

Male condoms	Rhythm
Female condoms	Withdrawal
Dental Dams	Depo-Provera
Birth Control Pills	Sterilization
Spermicidal Foam/Film	Emergency Contraceptive Pill
Spermicidal Sponge	(aka "Morning After" "Plan B")
Diaphragm	Other: ____________________
Intra-Uterine Device (IUD)	

Do you discuss safer sex with each partner? No Yes

How many sexual partners have you had in the last six (6) months? ____________

Have you ever had a sexually-transmitted infection?
Chlamydia Gonorrhea Herpes Genital Warts Other: ____________

How often do you use barrier methods (i.e. condoms, dental dams) during sexual activity?
Every time Sometimes Never

FEMALES ONLY:

How old were you when you had your first menstrual period? Are your periods regular? No Yes
Length of period: ________ days
How many days from the first day of one period to the first day of the next period? ________ days
Type of cramps: None Mild Moderate Severe Type of flow: Minimal Moderate Heavy
Do you ever notice spotting of blood between periods? No Yes
Have you ever had a pap smear? No Yes Date of last pap smear: ____________
Have you ever been treated for: Abnormal Pap Smear No Yes
Ovarian Cyst No Yes
Pelvic Inflammatory Disease No Yes
Have you ever been pregnant? No Yes How many pregnancies have you had? ______

Collection of information on this form is authorized under the Health Protection and Promotion Act, R.S.O., 1990, c.H.7, Section 5 for the provision of Family Planning Services and treatment and control of STDs. *Revised 08*