

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)			Depression		
High Blood Pressure			Anxiety		
Asthma			Hepatitis		
Thyroid Condition			Blood Clots		
Kidney Disorder			Heart Attack		
Breast Cancer			Diabetes		
Cervical Cancer			Other: _____		
Liver Disorder					
Tuberculosis					
Epilepsy					

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? _____