DENMARK MEDICAL CENTRE

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DENMARK Medical Centre

Accredited General Practice

Patient Questionnaire – 45-49 years old Health check

Name: ____ ***DOB:***____/____/____
Address:____
____

Occupation: ______________________**Birth Country/State**______________________

Aboriginal/Torres Strait Islander or other______________________________________

I ______________________________________give my consent for this health check

______________________________ date: _____________
signature

Please answer all the questions. If you don't know the month and year you think it happened, put a question mark next to your estimate.

1. Family history

Do you have a **family** history of any of the following? (Tick all that apply)

(1) Bowel cancer ☐ none ☐ 1 family member ☐ 2 or more family members

(2) Breast cancer ☐ none ☐ 1 family member ☐ 2 or more family members

(3) ☐ Diabetes

(4) ☐ Heart disease

(5) ☐ Substance Abuse eg; alcohol/drugs

(6) ☐ Other disease, please specify ______________________________

2. Medical History

(1) Have you have had any **past** medical conditions/diseases/operations?

☐ Yes Details: (i) Medical Conditions________________________

(ii) Operations ____________________________ ☐No

(2) Do you have any current medical conditions?

☐ Yes Details: ______________________________ ☐No

3. Cardiovascular

(1) When was your blood pressure last taken?

Date: ___ / __ / __ ☐ Unsure ☐ Never

(2) When were your cholesterol and triglycerides (fats in the blood) last tested?

Date: ___ / __ / __ ☐ Unsure ☐ Never

4. Cigarette smoking

Smoker ☐ Ex-smoker ☐ Never smoked ☐ **(got to Q5)**

(1) How many cigarettes do you smoke a day?

☐ 1-10 ☐ 11-15 ☐ 16-20 ☐ more than 20

(2) Are you interested in quitting smoking? ☐ Yes ☐ No ☐ Unsure

5. Exercise (in the past 7 days)

(1) How many times did you walk briskly for at least a total of 30 minutes, eg: for recreation, exercise or to get to and from places?

☐ None ☐ 1-2 x ☐ 3-4 x ☐ 5-7 x

(2) How many times were you moderately active in other ways (just as active as walking briskly) for at least a total of 30 minutes, eg: digging in the garden, golf, dancing, or tennis?

☐ None ☐ 1-2 x ☐ 3-4 x ☐ 5-7 x

(3) How often were you vigorously active for at least a total of 30 minutes, eg: jogging or running, tennis, swimming, bike riding, aerobics or fitness exercises?

☐ None ☐ Once ☐ Twice ☐ 3 or more times

6. Nutrition

How many portions of fruit and vegetables do you usually eat each day?

☐ None ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7 or more

Examples of a single portion

Fruit

- 1 medium size apple, banana, orange
- half a cup of fruit juice
- 4 dried apricots or 2 tablespoons sultanas
- 1 cup of canned or fresh fruit salad

Vegetables

-- ½ cup cooked vegetables (75g)

-- 1 medium potato

-- 1 cup salad vegetables

7. Alcohol

(1) How often do you drink alcohol? ☐Never **(Go to Q8)**

☐ Every day ☐5-6 Days a week ☐ 3-4 Days a week ☐ 1-2 Days a wee ☐ 1-2 Days a month

☐ Less than monthly

(2) On a day you drink alcohol, how many drinks do you usually have?

☐ 1-2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7-9 ☐ 10 or more

(3) How often do you have six or more drinks on one occasion?

☐ Never ☐ Monthly or less ☐ Weekly ☐ Daily or almost daily

In the past 12 months have you had any concerns about your drinking?

☐ Yes ☐ No ☐ Unsure

8. Mental health

(1) During the past month have you often been bothered by feeling down, depressed or hopeless? ☐Yes

☐ No ☐ Unsure

(2) Do you feel that you have someone to talk to or support you if you need to?

☐ Yes ☐ No ☐ Unsure

9. Immunisation

(1) When was your last tetanus booster?

Date: __ / __ /__ ☐ Unsure ☐ Never

(2) Have you had 3 doses of polio vaccine (drops or injection)?

☐ Yes ☐No ☐ Unsure

(3) When was the last time you were immunised against influenza?

Date: __ / __/__ ☐ Unsure ☐ Never

Women only

(4) Have you ever had rubella (German Measles) or the rubella vaccine?

☐ Yes ☐ No ☐ Unsure

10. Cancer

(1) Do you protect yourself from the sun when outdoors?

wear protective clothing:

☐ always ☐ often ☐ sometimes ☐ rarely ☐ never

use sunscreen creams:

☐ always ☐ often ☐ sometimes ☐ rarely ☐ never

Women only

(2) Have you had a Pap test in the past 2 years? ☐ Yes ☐ No ☐ Unsure

(3) Have you had any abnormal Pap results? ☐ Yes ☐ No

If Yes, details ______________________________

(4) Have you had a mammogram (breast X-ray) in the past 2 years? ☐ Yes ☐ No ☐ Unsure

If Yes, details ______________________________

Men only

(5) Have you had screening tests for Prostate Cancer? ☐ Yes ☐ No

If Yes, details ______________________________________

11. Medications

(1) Do you regularly use any non-prescription drugs (eg. over-the-counter)?

☐ Yes which ones? Please list __________________________ ☐ No

(2) Do you regularly use any herbal or other natural medicines?

☐ Yes which ones? Please list __________________________ ☐ No

(3) Do you use any recreational drugs (eg: Marijuana, speed, ecstasy)?

☐ Yes which ones? Please list __________________________ ☐ No

12. General Health

(1) Do you wear glasses? ☐ Yes ☐ No

(2) When was your last eye examination? Date: __/__/__

(3) Do you have any dentures/bridges/plates? ☐ Yes ☐ No

If Yes, details ______________________________

(4) When was your last dental examination? Date: __/__/__

(5) Do you have any allergies? ☐ Yes ☐ No

If Yes, details ______________________________

(6) In the past 12 months, have you had a fasting blood sugar level taken to test for diabetes?

☐ Yes ☐ No ☐ Unsure

14. What health topics would you like more information about?

____

____

____

____

PLEASE RETURN THIS COMPLETED QUESTIONNAIRE TO THE PRACTICE STAFF

LET THE DOCTOR KNOW IF YOU WOULD LIKE TO REVIEW THIS INFORMATION

ANOTHER APPOINTMENT MAY BE REQUIRED IF THERE IS A LOT TO COVER/DISCUSS

TO BE COMPLETED BY THE NURSE

BP ____/____ Pulse rate & Rhythm ________ _________per min

BSL _________mmols U/A ________________

Height ___________ cm Weight ____________kg BMI _________

Please complete Patient details:- Allergies, Family/Social Hx/Smoking & Alcohol status

Thank you.