WAKEFIELD GARDENS SURGERY

45 - 49 YEAR OLD HEALTH CHECK **Date:**

Name:

Address

DOB:

1/ Personal History

Do you have any of the following medical conditions

- Asthma or lung disease
- Diabetes
- Heart Disease
- Arthritis
- Anaemia
- High Blood Pressure
- Ulcers, Reflux or Bowel disease
- Cancer

1/ Family History

Has anyone in your family had any of the following conditions ?(Tick all that apply)

- Bowel cancer
- Breast cancer
- Ovarian cancer
- Melanoma
- Alcohol problems
- Diabetes
- Osteoporosis
- Other (specify):

2/ Do you smoke?

- If YES

How many cigarettes do you smoke a day now?

How keen are you to stop smoking?

Circle the number that best matches your current attitude from 0 (not very keen) to 7 (very keen).

0 1 2 3 4 5 6 7

If you decided to stop smoking right now, how confident of success would you be?

Circle the number that best matches your current attitude, from 0 (not at all confident) to 7 (very confident).

0 1 2 3 4 5 6 7

When you wake up each day, how soon do you smoke your first cigarette?

- If No

Have you ever smoked? For how long? When did you quit?

3/ Nutrition

Please circle one option for each question.

Have you lost weight recently without trying?	Y / N
Do you eat dairy products?	Y / N
Do you eat vegetables every day?	Y / N
Do you eat pies, pastries, fried foods or take-away meals more than once a week?	Y / N
Do you drink soft drinks, cordials, sports drinks or fruit juice on most days of the week?	Y / N
Do you eat meat?	Y / N

4/ Alcohol

How often do you drink alcohol?

Never (go to Q5)	Monthly or Less
2-4 times a month	2-3 times a week
4 or more times a week	Daily

How many standard drinks do you have on a typical day when you are drinking? (see diagram below)

1 or 2 3 or 4 5 or 6 7 to 9 10 or more

How often do you have 6 or more drinks on one occasion?

Never Less than monthly Monthly Weekly Daily or almost daily

5/ Physical Activity

Please circle one option for each question.

- How many times a week do you usually perform 20 minutes or more of vigorous-intensity physical activity that makes you sweat of puff & pant? (eg. heavy lifting, digging, jogging, aerobics or fast bicycling)

  0 1 2 3 4 5 6 7+

- How many times a week do you usually perform 30 minutes or more of walking? (eg. walking from place to place for exercise or recreation or moderate exercise)

  0 1 2 3 4 5 6 7+

6/ Weight Management

Please circle the options that apply to you

- Are you currently gaining weight without trying to? Y / N
- Have you gained more than 10kg since your late teens /early twenties? Y / N
- How many times have you tried to lose weight since you were in your late teens or early twenties?

  Never 1-3 times or more

  4 times or more I am always trying to lose weight

- How interested are you in managing your weight in the long term?

  Not Interested Quite Interested Very Interested

7/ Skin Cancer

Do you protect yourself from the sun when outdoors? (wear protective clothing, sunscreen)

Always Often Sometimes Rarely Never

Have you had a skin check in the last 12 months? Y / N

8/ Mental Health

During the past month have you often been bothered by feeling down, depressed or hopeless?

Yes No Unsure

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

Yes No Unsure

9/ Medication Usage

Do you regularly use any non-prescription or over-the-counter medications?

(eg. Panadol, Aspirin, Nurofen)

No Yes (Please List).....

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Do you regularly use any herbal or other natural medicines?

(eg. St John's wort, fish oil, Vitamins)

No Yes (Please List) .....

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Do you use any recreational or other drugs?

No Yes (please list).....

.....

10/ General Health

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

Yes No Unsure

In the past 12 months, have you had any concerns about incontinence (weak bladder)?

Yes No Unsure

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

Yes No Unsure

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

Yes No Unsure

For women

- Have you had a Pap Test in the last 2 years?

  Yes No Unsure

- Are you pregnant or breastfeeding?

***** PLEASE BRING THIS COMPLETED QUESTIONAIRE WITH YOU FOR**

REVIEW ON THE DAY OF YOUR HEALTH CHECK***