Office Use Only:

☐ Form Completed

☐ NP

☐ Existing

45-49 Year Old Health Check

This information is private and confidential and is for use in your clinical file only. It is a requirement that all files contain this information for accreditation purposes. Please print and give as much detail as possible to assist us to provide quality care.

PATIENT DETAILS

Mr Mrs Ms Miss Dr **Surname:** _____ **Given Name:** _____ **Middle Name:** _____

Date of Birth _____/_____/_____ **Ethnicity:** ☐ Australian ☐ Aboriginal ☐ TSI ☐ ATSI Other _____

Country Of Birth _____

Residential Address: _____ **Town:** _____ **Postcode:** _____

Postal Address: *(if different to home)* _____

Phone: _____ **Mobile:** _____ **Business:** _____

Email Address: _____ **Do you wish to receive electronic newsletters:** ☐ Yes ☐ No

Medicare No: _____ **Ref #** *(next to name)* _____ **Expiry:** _____

Veterans Affairs No: _____ ☐ Gold ☐ White - Condition/s: _____

Pension/Healthcare Card No: _____ **Expiry:** _____

Do you have private health care fund? ☐ Yes ☐ No **Fund Name:** _____ **Fund Number:** _____

Next of Kin: _____ **Relationship:** _____ **Phone:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Current Medications and Doses: _____

_____

Please list any known allergies and your reactions or list nil known if none: _____

_____

Please list any operations or previous illnesses: _____

_____

SOCIAL HISTORY - Please check the most appropriate answer fill out all other areas

Marital Status: ☐ Single ☐ Married ☐ De-facto ☐ Divorced ☐ Widowed ☐ Separated

Recreational Activities: _____

Accommodation: ☐ Own Home ☐ Rental ☐ Relatives ☐ Nursing Home ☐ Hostel ☐ Homeless ☐ Other

Lives with: _____ Is Carer: ☐ Yes ☐ No Has Carer: ☐ Yes ☐ No

If Yes, Carer Name: _____ **Address:** _____

Contact No: _____

PLEASE TURN OVER

Alcohol Consumption: Do you drink alcohol? ☐ Yes ☐ No If yes how much _____

Past Alcohol Consumption: ☐ Nil ☐ Light ☐ Moderate ☐ Heavy

Smoking: Do you smoke? ☐ Yes ☐ No If yes how many per day ? _____

Past Smoking History: ☐ Nil ☐ Light ☐ Moderate ☐ Heavy Which year did you stop smoking? _____

What is your Occupation?_____ **Past Occupation:**_____

FAMILY HISTORY - Please check the most appropriate answer fill out all other areas

Have you ever had: ☐ Diabetes ☐ Kidney Disease ☐ Asthma ☐ High Blood Pressure ☐ Heart Problems
☐ Breast Cancer ☐ Colon Cancer ☐ Stroke ☐ Depression ☐ Epilepsy ☐ Other Cancer

Family History: ☐ Unknown (eg Adopted) ☐ No significant family history ☐ Other – see list below

Mother: Still alive: ☐ Yes ☐ No If no Age at Death: _____
☐ Diabetes ☐ Kidney Disease ☐ Asthma ☐ High Blood Pressure ☐ Heart Problems
☐ Breast Cancer ☐ Colon Cancer ☐ Stroke ☐ Depression ☐ Epilepsy ☐ Other Cancer

Father: Still alive: ☐ Yes ☐ No If no Age at Death: _____
☐ Diabetes ☐ Kidney Disease ☐ Asthma ☐ High Blood Pressure ☐ Heart Problems
☐ Breast Cancer ☐ Colon Cancer ☐ Stroke ☐ Depression ☐ Epilepsy ☐ Other Cancer

Other immediate family members significant illness: _____
_____

Do you know your blood group? ☐ Yes ☐ No If yes, what group are you? _____

Cardiovascular

(1) When was your blood pressure last taken?
MM/YYYY
_____ / _____

☐ Unsure ☐ Never

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

☐ Unsure ☐ Never

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

PLEASE TURN OVER

Nutrition

(1) 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 or quarter rockmelon
- half a cup of fruit juice
- 4 dried apricots or 11/2 tablespoons of sultanas
- 1 cup of canned or fresh fruit salad

Vegetables

- half a cup of cooked vegetables (75 g)
- 1 medium potato
- 1 cup of salad vegetables

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

Immunisation

(1) When was your last tetanus booster?

MM/YYYY

_____ / _____

☐ Unsure ☐ Never

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

☐ Yes ☐ No ☐ Unsure

(3) Have you ever had immunisations for

Hepatitis ____/_____/_____

Influenza ____/_____/_____

Pneumonia ____/_____/_____

Skin Cancer

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

A.

☐ wear protective clothing

☐ always often

☐ sometimes rarely

☐ never

B.

☐ use sunscreen creams

☐ always often

☐ sometimes rarely

☐ never

Have you ever had your skin checked? ☐ Yes ☐ No

PLEASE TURN OVER

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

Do you ever have trouble with your bladder/urine flow?

☐ Yes ☐ No ☐ Unsure

Women Only

Have you had a Pap test in the past 2 years?

☐ Yes ☐ No ☐ Unsure

Is there any additional health information that you would like to add?

_____

_____

_____

_____

This questionnaire remains private and confidential.
The information gathered in this questionnaire is for use in your child's personal medical file only.

PLEASE FILL OUT THE DETAILS AND RETURN TO RECEPTION AT PELICAN WATERS FAMILY DOCTORS AT LEAST 2 DAYS PRIOR TO YOUR APPOINTMENT

THANK YOU