Date:	Name:	DOB:

1. Family history

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

☐ Cancer (type: ……)
☐ Melanoma
☐ Cardiovascular disease
☐ Mental Health issues
☐ Alcohol problems
☐ Diabetes
☐ Osteoporosis
☐ Asthma

☐ Other*(specify)*:.....

2. Smoking

(a) Do you smoke? ☐ Yes

How many cigarettes do you smoke a day now?.....

☐ No, but I use to smoke

When did you quit? (Month) …… (Year) ……
Past smoking history:

- ☐ Light
- ☐ Moderate
- ☐ Heavy

☐ No, never smoked **(go to Q3)**

(b) How keen are you to stop smoking?

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

0 1 2 3 4 5 6 7

(c) 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

3. Nutrition

Please circle **one** option for each question.

Part 1:

Are you pregnant or breastfeeding? **Y / N**
Have you lost weight recently without trying? **Y / N**
Do you have diabetes and use insulin or take oral medication for your diabetes? **Y / N**
Do you have anaemia caused by iron deficiency? **Y / N**
Do you have osteoporosis? **Y / N**
Is it difficult for you to shop or cook for yourself? **Y / N**

Part 2:

Do you choose low-fat 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**

4. Alcohol
1 STANDARD DRINK =

(a) How often do you drink alcohol?

☐ Never **(go to Q5)**
☐ Monthly or less
☐ 2 –4 times/month
☐ ……..days per week

(b) How many standard drinks do you have on a typical day when you are drinking? **(See diagram above)**

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

(c) 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

(a) How many times a week do you usually perform 30 minutes or more of physical activity?

0 1 2 3 4 5 6 7+

(b) I would describe the intensity of my physical activity as:

- ☐ Light
- ☐ Moderate (increases heart rate & makes your breathing harder than normal)
- ☐ Heavy (increases heart rate, sweating & makes you puff/pant)

6. Weight Management

(a) Have you recently gained weight? **Y / N**

(b) Would you like support in weight management**?** **Y / N**

7. Skin cancer

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

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

8. Mental Health

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

☐ Yes

☐ No ☐ Unsure

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

☐ Yes

☐ No

☐ Unsure

9. Medication Usage

(a) Do you regularly use any non-prescription drugs? (*E.g. Panadol, Aspirin*) or Herbal/ Natural medicines (Eg. fish oil, vitamins, st johns wart)

☐ No

☐ Yes (*Please list*)……

(b) Do you use any recreational drugs? (*E.g. marijuana, speed*)

☐ No

☐ Yes (*Please list*)……

10. General health

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

☐ Yes

☐ No

☐ Unsure

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

☐ Yes

☐ No

☐ Unsure

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

☐ Yes

☐ No

☐ Unsure

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

☐ Yes

☐ No

☐ Unsure

12. WOMEN ONLY

(a) Have you had a Cervical Screening test in the past 5 years? ☐Yes☐ No☐ Unsure

(b) Do you regularly perform breast self examinations?

☐ Yes

☐ No

*****PLEASE BRING THE COMPLETED QUESTIONNAIRE WITH YOU FOR REVIEW ON THE DAY OF YOUR HEALTH CHECK *****