The 45-49 Year Old Health Check Questionnaire

BLACKBURN CLINIC
FAMILY GENERAL PRACTICE

Please return this questionnaire to the doctor at the time of your 45-49 Year Old Health Check. When booking your 45-49 Year Old Health Check please ask for a double appointment.

PATIENT DETAILS

Date questionnaire completed: _____

Name: _____ File No: _____

Address: _____

Marital status: _____ Date of Birth: _____

No. of children: _____ Occupation: _____

This questionnaire will allow your doctor to have a complete picture of your current health status and is required for your optimal medical care. Please fill out all details as accurately as possible. If you are unsure about a question, ask your doctor. It will be kept in your medical history and is strictly confidential.

GENERAL MEDICAL QUESTIONS

List all of your current medications, with dosages if known (including the contraceptive pill and any non-prescription drugs or herbal products you take). _____

_____

_____

Do you have any allergies to medications? ☐ NO ☐ YES_____

Do you have any other allergies ☐ NO ☐ YES_____

When was your last tetanus/ADT vaccine? _____

Have you had an MMR (measles/mumps/rubella) vaccine? ☐ NO. ☐ YES When? _____

Have you had other vaccinations? ☐ NO. ☐ YES, Types _____

What year was your last:

Eye check	_____	Skin check	_____
Glucose (diabetes) test	_____	Bowel cancer check	_____
Cervical screen (females)	_____	Cholesterol test	_____
Mammogram (females)	_____	Prostate check(males)	_____
Blood Pressure test	_____		

Smoking: ☐ Smoker ☐ Ex-smoker ☐ Never smoked

Frequency: ☐ Daily ☐ Weekly ☐ Less than weekly

Number of cigarettes? _____ Year commenced? _____

Ready to Quit? : ☐ Not ready ☐ Unsure ☐ Ready ☐ Recent Quitter

Last Quit attempt? _____ Duration of longest period of abstinence? _____

Alcohol: How often do you drink alcohol?

☐ Never ☐ Monthly/less ☐ 2-4 per Month ☐ 2-3 per Week ☐ 4 plus per Week

How many standard drinks containing alcohol do you have on a typical day?

☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-6 ☐ 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

How many times a week do you usually do 20 minutes of vigorous physical activity that makes you sweat or puff and pant? _____

How many times a week do you usually do 30 minutes of moderate physical activity or brisk walking that increases your heart rate or makes you breathe harder than normal? _____

What hobbies/interests do you have? _____

Do you have a special diet? ☐ NO ☐ YES

Do you have any home help or assistance? ☐ NO ☐ YES

PERSONAL MEDICAL HISTORY

Do **YOU** have a past history of any of the following?

CONDITION	YES	NO	Don't Know	DOCTOR'S COMMENTS
High Cholesterol				
High blood pressure				
Diabetes				
Asthma				
Hay fever				
Eczema				
Epilepsy				
Stroke				
Heart Attack				
Angina				
Cancer				
Hearing problems				
Vision or eye problems				
Arthritis				
Kidney disease				
Rheumatic fever				
Blood disorders				
Psychiatric disorders/ depression/ anxiety				
Gynaecological problems				
Pregnancies/problems				
Clotting disorder				

Significant injuries(please list)_____

Operations(please list) _____

Other problems(please list) _____

FAMILY MEDICAL HISTORY

Has anyone in your **FAMILY** (parents/siblings/children only) had any of the following conditions?

CONDITION	YES	NO	Don't Know	FAMILY MEMBER	AGE OF. ONSET
Diabetes					
High blood pressure					
High cholesterol					
Angina					
Stroke/ Heart attack					
Asthma					
Glaucoma					
Blood disorders					
Clotting disorder					
Psychiatric disorders					

Cancer(list type) _____

Congenital/Genetic disorders(please list) _____

Other significant problems(please list) _____