

# BLACKBURN CLINIC

195 Whitehorse Rd, Blackburn, 3130. Phone: 9875 1111, Fax: 9875 1100

## COMPLETE HEALTH CHECK QUESTIONNAIRE

RECEPTION STAFF TO COMPLETE

**Your appointment details:**

Date: \_\_\_\_\_ Time: \_\_\_\_\_

File No. \_\_\_\_\_

GP name: \_\_\_\_\_

*This questionnaire is required in order for 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 please ask your doctor. It will be kept with your medical history and is strictly confidential. Please note that the "Complete Health Check" appointment is designed to screen for and identify current problems and future risk. If major issues arise these may require a further appointment. Follow up consultations may incur a charge.*

### For your appointment:

- bring any **medications** that you are taking;
- bring **glasses** if you wear them (reading and distance).

We will need a **urine sample** on the day. You may provide the sample at your appointment, or:

- bring your sample in a clean jar from home; or
- collect a urine specimen jar from the clinic prior to your appointment in order to bring your sample from home.

Your appointment will include a variety of tests to be run by our **nurse** as well as time spent with your **GP**. You should expect your appointment to take **approximately One hour and thirty minutes**.

Full payment is requested on the day and after Medicare rebates the remaining out of pocket GAP will be:

\$200 for Mon-Fri appointments

\$240 for weekend appointments.

*(prices from 1 Jan 2026)*

A fee of \$70 is charged for non-attendance with less than 3 days notice. Please call 9875 1123 at least three days prior to your appointment if you need to reschedule.

**Please return the attached questionnaire to Blackburn Clinic as soon as possible. Your doctor will need this information 4 days prior to your appointment.**

**E: [admin@blackburnclinic.com.au](mailto:admin@blackburnclinic.com.au)**

**Post: PO Box 42, Blackburn South 3130 (allow one week if posting)**

**Please keep this information sheet for your visit.**

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# BLACKBURN CLINIC – COMPLETE HEALTH CHECK QUESTIONNAIRE

PO Box 42, Blackburn South, 3130. Phone: 9875 1111, Fax: 9875 1100

Your appointment details: Date: _____ Time: _____
File No. _____ GP name: _____

## PATIENT DETAILS

Date questionnaire completed: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Mobile \_\_\_\_\_

Marital status: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

How do you describe your gender?

Male     Female     Non-binary     I / They     Prefer not to say

What was your sex recorded at birth? We ask this question because the recommended health screenings relate to this.     Male     Female

No. of children: \_\_\_\_\_ Occupation: \_\_\_\_\_

Have you had a Complete Health Check (previously called a Men's or Women's Health Check at Blackburn Clinic) previously?     No     Yes, date:.....

## PAST MEDICAL HISTORY

CONDITION	YES	NO	DON'T KNOW	N/A	FURTHER DETAILS
High cholesterol					
High blood pressure					
Diabetes					
Asthma					
Hay Fever					
Eczema					
Allergies					
Allergies to medications					Specify:
Epilepsy					
Stroke					
Angina					
Heart attack					When:
Heart surgery					Type: When:
Cancer					Type:
Hearing problems					
Vision problems					
Arthritis					
Kidney disease					

**PAST MEDICAL HISTORY (con't)**

CONDITION	YES	NO	DON'T KNOW	N/A	FURTHER DETAILS
Rheumatic fever					
Blood disorders					
Psychiatric problems					
Urinary tract infections					
Any operations or other hospitalisations					Please specify:
Any other medical conditions					Please specify:
Significant injuries					Please specify:
Use of Hormone Replacement Therapy					
Problems during pregnancy					Please specify:
Contraception history					Please specify:
Menstrual history (eg. Endometriosis)					Please specify:
Abnormal smear/ cervical screening test					

**MEDICATIONS:**

List all of your current medications, with dosages if known (including non-prescription drugs):

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Please bring any medications including Vitamins, health supplements or alternative therapies with you.

**DIET:**

Vegan

Vegetarian

How many serves of DAIRY per day? \_\_\_\_\_

How many serves of PROTEIN per day? \_\_\_\_\_

**SMOKING:**

Do you smoke?

No

Yes

Do you wish to quit?  No

Yes

How many cigarettes per day? \_\_\_\_\_

Have you ever smoked?

No

Yes

When did you quit? \_\_\_\_\_

How many years did you smoke? \_\_\_\_\_

**ALCOHOL:**

How often do you have a drink containing alcohol?

- Never     
 Monthly or less     
 Once per week     
 2-4 times per week     
 5+ times per week.

**A "standard drink"** is defined as:

285ml (one pot) of full strength beer	100ml (small glass) of wine
375ml (one can) of light strength beer	30ml (one nip) of spirits

When you drink alcohol, do you consume more than 6 standard drinks?

- Usually     
 Sometimes     
 Rarely     
 Never

Please make an honest assessment of your average number of standard alcoholic drinks per week.

- Less than 10     
 10 to 20     
 30 to 40     
 Over 40

**EXERCISE:**

What sports do you play?

\_\_\_\_\_

\_\_\_\_\_

How many times per week?

\_\_\_\_\_

\_\_\_\_\_

Do you do any other exercise (eg. Walking)?

\_\_\_\_\_

How many times per week?

\_\_\_\_\_

**WHEN WAS THIS LAST CHECKED / MEASURED?**

Date

Prostate check? \_\_\_\_\_

Cholesterol? \_\_\_\_\_

Result? \_\_\_\_\_

Blood pressure? \_\_\_\_\_

Result? \_\_\_\_\_

Mammogram? \_\_\_\_\_

Result? \_\_\_\_\_

Cervical screen/ Pap smear? \_\_\_\_\_

Result? \_\_\_\_\_

**IMMUNISATIONS:**

Last immunisation / vaccination of each of the following:

	No	Yes	Date	Don't know
Tetanus				
Hepatitis A				
Hepatitis B				
Polio				
Chicken Pox				
Whooping Cough				
Flu				
Covid-19				

**DO YOU SUFFER FROM:**

	YES	NO	N/A		YES	NO	N/A
Headaches				Poor sleeping patterns			
Chest pains				Excessive shyness			
Shortness of breath				Fits of anger			
Abdominal pains				Depression			
Irregular bowel habit				Anxiety			
Blood in bowel actions				Nervousness			
Chronic cough							
Back or neck pain							
Period problems				Poor erections			
Hot flushes				Poor urinary flow pressure			
Urine leakage							
Poor libido / sexual problems				Other symptoms of concern to you			

	YES	NO
Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?		
Do you have unusual sleepiness during the day?		
Has anyone observed you stop breathing during your sleep?		

**FAMILY HISTORY:** Have any of your blood relatives suffered from:

CONDITION	YES	NO	DON'T KNOW	N/A	FURTHER DETAILS (Who & at what age)
High cholesterol					
Heart attack					
Heart surgery					
Angina					
Diabetes					
Stroke					
Glaucoma					
Blood disorders					
Haemochromatosis					
Psychiatric disorders					
Depression					
Alzheimers					
Osteoporosis					
Prostate disease					
Cancer					Type: Who: At what age:

(Feb 2026)