Southside Family Health Centre

CENTRAL HEALTH medical practice

DR LUCY LORD • DR RULIN FUONG • DR SARAH BORWEIN

Island Health Family Practice

Health Screen Questionaire - MEN

Name: _____ Date of Birth: _____

Occupation: _____ Marital Status: _____

Date: _____ Doctor: _____

Current Health

Is there any special reason you have decided to have this medical? _____

_____

Have you seen any GP's, Specialists or health professionals in the last 6 months? Yes ☐ No ☐

Reason: _____

Do you currently, or have you recently suffered from any of the following?

	Yes		Yes		Yes
Shortness of breath	☐	Dizziness	☐	Skin problems	☐
Wheezing	☐	Hearing problems	☐	Joint pain	☐
Coughing	☐	Visual changes	☐	Back pain	☐
Palpitations	☐	Indigestion	☐	Weight changes	☐
Chest pain	☐	Diarrhoea	☐	Sexual problems	☐
Poor circulation	☐	Constipation	☐	Insomnia	☐
Headaches	☐	Rectal bleeding	☐	Fever	☐
Fits/convulsions	☐	Urinary problems	☐		

Allergies

Do you have any allergies? _____

Do you protect yourself from the sun (hats/clothing)? Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never ☐

Do you use sunscreen creams? Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never ☐

Smoking

Do you: Currently smoke ☐ Wish to quit smoking ☐ Quit smoking ☐ (when?) _____ Never smoked ☐

Alcohol

How often do you drink?

Every day ☐ Most days ☐ Once or twice per week ☐ Weekdays only ☐ Special occasions ☐ Never ☐

Has your alcohol consumption increased over the last year? Yes ☐ No ☐

Do you ever feel you should cut down your drinking? Yes ☐ No ☐

Have you ever taken recreational drugs? Yes ☐ No ☐

Exercise

How often do you exercise? (days per week) _ _ _ _ _ _ _ _

Nutrition

	Yes	No		Yes	No
Do you eat 3 meals a day?	☐	☐	Do you eat fruit or vegetables most days?	☐	☐
Do you eat dairy produce most days?	☐	☐	Do you have 6-8 cups of fluids most days?	☐	☐
Without wanting to, have you gained or lost more than 3 kilos in the last 6 months?	☐	☐	Are you on any 'special' diet (ie. lactose or gluten free / vegan / halal)?	☐	☐

Mood/Sleep

During the last 4 weeks how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, downhearted or blue?

Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely ☐

Do you feel that you have someone to talk to or support you if needed? Yes ☐ No ☐ Unsure ☐

Medication

Please list any medications taken (including vitamins, supplements, traditional chinese medicine) during the past 6 months:

_ _

_ _

Vaccination Record

Please tick vaccinations received;	Yes	No	
Tetanus	☐	☐	
Diphtheria and Pertussis	☐	☐	
Hepatitis A	☐	☐	
Hepatitis B	☐	☐	
Measles-Mumps-Rubella (MMR)	☐	☐	
Varicella	☐	☐	
Polio (please list if received booster)	☐	☐	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Travel + Specific

Influenza	☐	☐
Typhoid	☐	☐
Rabies	☐	☐
Japanese Encephalitis	☐	☐
Meningococcal	☐	☐
Yellow Fever	☐	☐

Others (please list) _

_ _

_ _

Current Health continued...

Men's Health

	Yes	No	
Are you sexually active?	☐	☐	
Is intercourse painful?	☐	☐	
Have you had any sexually transmitted diseases?	☐	☐	Please explain: _____
Do you use contraception?	☐	☐	Please explain: _____
Do you have children?	☐	☐	If so, how many? _____
Have you experienced problems conceiving?	☐	☐	
If so, have you had treatment for infertility?	☐	☐	
Do you ever have difficulty urinating?	☐	☐	

Past Medical History

Have you ever suffered from any of the following? Please tick and write age of onset:

	Yes	Age		Yes	Age		Yes	Age
High blood pressure	☐	_____	Tuberculosis	☐	_____	Anaemia	☐	_____
High cholesterol	☐	_____	Epilepsy	☐	_____	Hepatitis	☐	_____
Heart attack	☐	_____	Hernia	☐	_____	Back pain	☐	_____
Stroke	☐	_____	Urinary problems	☐	_____	Malaria	☐	_____
Angina	☐	_____	Kidney stones	☐	_____	Eye disease	☐	_____
Rheumatic fever	☐	_____	Gall stones	☐	_____	Anxiety	☐	_____
Diabetes	☐	_____	Stomach ulcer	☐	_____	Depression	☐	_____
Thyroid disease	☐	_____	Stomach problems	☐	_____	Skin disease	☐	_____
Bronchitis	☐	_____	Asthma	☐	_____	Prostate cancer	☐	_____
Hayfever	☐	_____						

Please list any other significant illnesses: _____

_____

Please list any operations/hospitalizations or accidents: _____

_____

Please list anything else which concerns you about your health: _____

_____

_____

_____

_____

Family Medical History

	Yes	No	
Is your biologial father alive?	☐	☐	If so, how old is he?
Does he have any health problems?	☐	☐	Please explain;
If deceased, what was the cause of his death?			
Is your biological mother alive?	☐	☐	If so, how old is she?
Does she have any health problems?	☐	☐	Please explain;
If deceased, what was the cause of her death?			
Are your siblings alive?	☐	☐	
Have they suffered from any significant illnesses?			

Is there any family history of:	Yes	No
High blood pressure	☐	☐
High cholesterol	☐	☐
Diabetes	☐	☐
Heart attack / heart disease	☐	☐
Stroke	☐	☐
Epilepsy	☐	☐
Cancer	☐	☐
Thyroid disease	☐	☐
Depression / anxiety	☐	☐
Glaucoma	☐	☐

Is there anything that runs in your family that you are concerned about?