

Patient Practice Prevention Survey – Adult

Name	Ethnicity	Date	Time
Please answer all the questions. If you don't know the month and year you think it happened, put a question mark next to your estimate.			
<p>1. Family history</p> <p>Do you have a family history of any of the following? (Tick all that apply)</p> <p>(1) <input type="checkbox"/> Alcohol problems</p> <p>(2) Bowel cancer <input type="checkbox"/> none <input type="checkbox"/> 1 family member <input type="checkbox"/> 2 or more family members</p> <p>(3) Breast cancer <input type="checkbox"/> none <input type="checkbox"/> 1 family member <input type="checkbox"/> 2 family members</p> <p>(4) <input type="checkbox"/> Diabetes</p> <p>(5) <input type="checkbox"/> Heart disease</p> <p>(6) <input type="checkbox"/> Other disease, please specify</p> <p>_____</p>		<p>4. Exercise (in the past 7 days)</p> <p>(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? <input type="checkbox"/> None <input type="checkbox"/> 1–2 x <input type="checkbox"/> 3–4 x <input type="checkbox"/> 5–7 x</p> <p>(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? <input type="checkbox"/> None <input type="checkbox"/> 1–2 x <input type="checkbox"/> 3–4 x <input type="checkbox"/> 5–7 x</p> <p>(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? <input type="checkbox"/> None <input type="checkbox"/> Once <input type="checkbox"/> Twice <input type="checkbox"/> 3 or more times</p>	
<p>2. Cardiovascular</p> <p>(1) When was your blood pressure last taken? MM/YYYY ____ / ____ <input type="checkbox"/> Unsure <input type="checkbox"/> Never</p> <p>(2) When were your cholesterol and triglycerides (fats in the blood) last tested? ____ / ____ <input type="checkbox"/> Unsure <input type="checkbox"/> Never</p>		<p>5. Nutrition</p> <p>(1) How many portions of fruit and vegetables do you usually eat each day? <input type="checkbox"/> None <input type="checkbox"/> 1–2 <input type="checkbox"/> 3–4 <input type="checkbox"/> 5–6 <input type="checkbox"/> 7 or more</p> <p>Examples of a single portion</p> <p>Fruit</p> <ul style="list-style-type: none"> – 1 medium size apple, banana, orange or quarter rockmelon – half a cup of fruit juice – 4 dried apricots or 1½ tablespoons of sultanas – 1 cup of canned or fresh fruit salad <p>Vegetables</p> <ul style="list-style-type: none"> – half a cup of cooked vegetables (75 g) – 1 medium potato – 1 cup of salad vegetables 	
<p>3. Cigarette smoking</p> <p>(1) How many cigarettes do you smoke a day? <input type="checkbox"/> None <i>go to Q4)</i> <input type="checkbox"/> 1–10 <input type="checkbox"/> 11–15 <input type="checkbox"/> 16–20 <input type="checkbox"/> more than 20</p> <p>(2) Are you interested in quitting smoking? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure</p>			

(2) What is your weight? kg

_____ / _____

(3) What is your height? cm

_____ / _____

6. Alcohol

(1) How often do you drink alcohol?

Never *Go to Q7*

Monthly

2-3 times 2-4 times

4-6 times Every day

(2) On a day you drink alcohol, how many drinks do you usually have?

1-2 3 or 4

5 or 6 7-9

10 or more

(3) How often do you have six or more drinks on one occasion?

Never Monthly or less

Weekly Daily or almost daily

In the past 12 months have you had any concerns about your drinking?

Yes No

Unsure

7. 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

8. 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

Women only

(3) Have you ever had rubella (german measles) or the rubella vaccine?

Yes No

Unsure

9. Cancer

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

wear protective clothing

always often

sometimes rarely

never

use sunscreen creams

always often

sometimes rarely

never

Women only

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

Yes No

Unsure

10. Medications

(1) Do you regularly use any nonprescription 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

Those age less than 50 years go to Q13

11. For those 50 years and older

(1) In the past 2 years have you used a special kit (bowel cancer testing kit) to test your stool (poo) for blood?

Yes No

Unsure

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

- Yes No
 Unsure

Women only

(2) Have you had a mammogram (breast X-ray) in the past 2 years?

- Yes No
 Unsure

12. For those 65 years and over

Those age 50-64 years go to Q13

(1) When was the last time you were immunised against influenza?

MM/YYYY

_____ / _____

- Unsure Never

(2) When was the last time you were immunised against pneumococcal pneumonia?

MM/YYYY

_____ / _____

- Unsure Never

(3) Have you had a fall in the past year?

- Yes Did you injure yourself?

- No

(4) Have you had your vision checked in the past year?

- Yes No
 Unsure

(5) Have you had your hearing checked in the past year?

- Yes No
 Unsure

(6) Do you ever have trouble with your bladder?

- Yes No
 Unsure

Do you ever lose your urine or get wet?

- Yes No

13. What health topics would you like more information about?

PLEASE RETURN THIS COMPLETED QUESTIONNAIRE TO THE PRACTICE STAFF

LET THE DOCTOR KNOW IF YOU WOULD LIKE TO REVIEW THIS INFORMATION

ANOTHER APPOINTMENT MAY BE REQUIRED IF THERE IS A LOT TO COVER/DISCUSS