WELLNESS CHECK QUESTIONAIRRE

Date:_____

Name	☐ Male ☐Female	**DOB:**
Marital status:	☐ Single ☐ De-Facto ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Occupation:		

PERSONAL HEALTH HISTORY

Do you have any allergies? If yes please give details:		
Is your health impaired in any way? If yes please give details:		
Are you considering seeking advice, tests or surgery for your health? If yes please explain:		
Do you suffer or have you ever suffered from, or have you ever had treatment, surgery, medical tests or prescribed medication for any of the following?		
Chest pain, tightness, angina		If Yes please explain:
Palpitations, irregular heartbeat		
High Blood Pressure		
High Cholesterol		
Diabetes		If Yes Type 1 or Type 2
Do you have any suspicious moles? If yes please provide details:		
Please list all the operations and any serious injuries you have had:		

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

LIFESTYLE

Exercise	☐ Sedentary (No exercise)		
	☐ Mild exercise (e.g climbing stairs, golf)		
	☐ Occasional vigorous exercise (work or recreation, less than 4x/week for 30 min)		
	☐ Regular vigorous exercise (work or recreation more than 4x/week for 30 minutes)		
Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	If yes, how many drinks per week?		
Smoking Status	☐ Current Smoker ☐ Ex-Smoker ☐ Never Smoked		
	If current smoker how many per day?	☐ # of years	
Drug use	Have you used any other drugs?	If Yes please provide further details	

MENTAL HEALTH

How is your mood?	☐ Good	☐ Low
How are your motivation and energy levels?	☐ Good	☐ Low
Do you worry a lot?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Have you had any changes in your weight over the last year?	☐ Yes	☐ No
Do you watch what you eat?	☐ Yes	☐ No
Do you have hobbies you enjoy?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Do you have any trouble with your memory	☐ Yes	☐ No

ADVANCED CARE PLANNING

Are you interested in Advance Care Planning? ☐ Yes ☐ No

Advanced Care Planning is about starting a discussion about what to do in the event that your health worsens, you become unable to make decisions about your health or if faced with a life-limiting illness

FAMILY HEALTH HISTORY

Do you have any family history of Heart Disease/Cancer/Diabetes/Clots/Stroke/Mental Health Issues

	AGE	DETAILS		AGE	DETAILS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

Do you experience or have you experienced any of the following?

☐	Breathing problems (Including asthma, bronchitis, respiratory disease)	☐	Kidney disease (urinary tract infections or stones)
☐	Chronic Cough	☐	Bladder, urinary or prostate condition
☐	A change in hearing	☐	Exposure to excessive noise
☐	A change in vision		
☐	Brain or neurology disorder (including epilepsy and stroke)		
☐	Headaches		

WOMEN ONLY		
Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last smear test?		
Bowel Motions regular?	☐ Yes	☐ No
Indigestion, heartburn or reflux?	☐ Yes	☐No
Any changes in bowel habits?	☐ Yes	☐No

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Liver or gall bladder disease	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Thyroid disorder	☐ Yes	☐ No
Gastro-Intestinal problems (including bowel complaints, ulcers or colitis)	☐ Yes	☐ No
Bowel Motions regular	☐ Yes	☐ No
Any changes in bowel habits	☐ Yes	☐ No
Indigestion, heartburn or reflux?	☐ Yes	☐ No
Arthritis or rheumatism (including any disease of disorder to bones, muscles or joints)	☐ Yes	☐ No
Gout	☐ Yes	☐ No
Hernias	☐ Yes	☐ No
Sexual Health Problems (including erectile, premature ejaculation or libido)	☐ Yes	☐ No
Cancer, any lumps or cysts?	☐ Yes	☐ No

Is there any further information you wish to add?

_____

_____

_____

_____

Doctor to Complete

Screening

Ht	
Wt	
BMI	
Waist	
BP	
HR	R/I

Examination

VA	
Throat/neck	
Lungs	
CVS	
Abdo	
MSK/neuro	
Moles/skin	
DRE (men)	
Specific complaint	

Diagnostic

Hearing	
FBC	
U&E	
LFT	
TFT	
Lipid (ratio)	
HbA_{1C}	
CVDRA (%)	
Urine dip	
PSA (men)	
Fe studies (women)	

Comments/abnormal findings

Abbreviations

FBC	Full blood count
U&E	Urea and electrolytes (renal function)
LFT	Liver function tests
TFT	Thyroid function tests
CVDRA	Cardiovascular disease risk assessment