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 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:

- do a **RAT test** on the day as you will be performing a **lung function test (if the result is Positive, please phone the clinic to reschedule 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 fifteen minutes**.

Although most patients pay in full (as Medicare rebates are usually same day for registered bank accounts), all patients should come prepared to pay at least the gap on the day:

$150 for Mon-Fri appointments
$170 for weekend appointments. *(May 2023)*

Appropriate Medicare item numbers will also be billed, and Medicare will send a cheque to the patient (made out to your doctor), which must be sent on to Blackburn Clinic.

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

Please keep this information sheet for your visit.

BLACKBURN CLINIC – COMPLETE HEALTH CHECK QUESTIONNAIRE

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

RECEPTION STAFF TO COMPLETE

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):

_____

_____

_____

_____

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:

(May 2023)