

# **Patient Questionnaire**

## **for Health Support Service for Dioxin Exposed People Annual Health Check**

- Practice use only

## Name

Given or First Names

Surname or Family Name

Date of Birth

Day

Month

Year

NHI Number (if known)

Usual GP

If you are not seeing your usual GP, do you agree to your GP receiving a copy of the report?

Yes

No

## Medical history and current conditions:

List current conditions and medications **if not known** by doctor conducting examination

*Please note any diabetes, lung, heart or circulation, cancer, or mental health problems.*

**Disease/condition (past or present):**      **Current medications:**


**Current health:** *Tick box if you have noticed:*

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Abnormal bleeding  | <input type="checkbox"/> Change in bowel habit             | <input type="checkbox"/> Unexpected weight loss                    |
| <input type="checkbox"/> New (or change) to skin moles/lumps                                  | <input type="checkbox"/> Abnormal lumps or swelling        | <input type="checkbox"/> Low mood, depression or excessive anxiety |
| <input type="checkbox"/> Sleep problems   | <input type="checkbox"/> Unusual tiredness                 | <input type="checkbox"/> Problems passing urine                    |
| <input type="checkbox"/> Breathing difficulty including shortness of breath, chest pain, etc. | <input type="checkbox"/> Skin problems including itchiness | <input type="checkbox"/> Numbness                                  |
| <input type="checkbox"/> Persistent night sweats or unexplained fever                         |  |  |
| <input type="checkbox"/> Any other troublesome or concerning symptom                          |  |  |

**Recent tests/health checks:**

- |   |                              |                             |  |
|---|------------------------------|-----------------------------|--|
| Have you had recent blood tests (eg, cholesterol)?                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |  |
| Have you recently had a chest X-ray?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |  |
| Do you smoke?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If Yes, how many cigarettes daily? <input type="text"/>          |
| Are you concerned about your smoking?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |  |
| Would you like assistance quitting?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |  |
| Are you concerned about your weight and diet?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |  |
| Do you exercise (moderate or vigorous) at least 30 minutes daily 5 or more days a week? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |  |
| Would you like advice/assistance about your weight, diet or exercise?                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |  |
| Do you drink alcohol?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, how many standard drinks each week? <input type="text"/> |
| Do you use other drugs?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, please provide details:<br><input type="text"/>          |
| Are you concerned about your alcohol or drug use?                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |  |
| Would you like advice/assistance about your alcohol or drug use?                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |  |

**Over the last three months:** *Circle most appropriate answer*

Have you felt sad or depressed?	Yes often	A little	No
Have you felt worthless or suicidal?	Yes often	A little	No
Have you felt angry or frustrated?	Yes often	A little	No
Have you hurt or felt like hurting someone?	Yes often	A little	No
Do you have disturbing or unreal thoughts?	Yes often	A little	No

**Women:**

	<b>Date</b>						
Most recent cervical smear	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Day	Month	Year				
Most recent mammogram	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Day	Month	Year				

**Men:**

	<b>Date</b>						
Have you had a PSA test?	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Day	Month	Year				