**SURNAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIRST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **To assist with health initiatives - Are you of Aboriginal origin?** [ ]  Yes [ ]  No

 **Are you of Torres Strait Islander origin?** [ ]  Yes [ ]  No

**Do you have any allergies or are you sensitive to drugs or dressings:**

 [ ]  Yes (If yes, please list below) [ ]  No

|  |  |
| --- | --- |
|  **Allergic to:** |  **Reaction is:** |
|  |  |
|  |  |
|  |  |

**Marital Status:**  [ ]  Single [ ]  Married [ ]  Defacto [ ]  Widowed [ ]  Divorced [ ]  Separated [ ]  Other

**Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Alcohol Intake-Fill in the number of days you usually drink alcohol**

[ ]  Never (Non-Drinker) [ ]  Less than monthly [ ]  1-2 Days a month

[ ]  1-2 Days a week [ ]  3-4 Days a week [ ]  5-6 Days a week [ ]  Everyday

**On a day you drink, how many standard drinks per day? \_\_\_\_\_\_**

**Concerned about your drinking?** [ ] Yes [ ]  No [ ]  Don’t know

**Past Alcohol Intake** [ ]  Nil [ ]  Occasional [ ]  Moderate [ ]  Heavy Year stopped: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Smoking**

[ ]  Smoker-number per day\_\_\_\_\_\_\_\_ [ ]  Ex-Smoker-year ceased smoking \_\_\_\_\_\_\_\_\_ [ ]  Non-Smoker

**Past Smoking (if ex-smoker)**

**Quantity per day**  [ ]  Unknown [ ]  <1 [ ]  1-9 [ ]  10-19 [ ]  20-39 [ ]  40+

**Would you like cessation advice/support?** [ ] Yes [ ]  No [ ]  Don’t know

|  |
| --- |
|  **Your Health History – Please tick if you have or had a history of** |
|  [ ]  Asthma |  [ ]  Mental Illness-Type: |
|  [ ]  Diabetes |  [ ]  Chronic Illness-Type: |
|  [ ]  Heart Disease |  [ ]  Cancer-Type: |
|  [ ]  High Blood Pressure |  [ ]  Other - Specify |

**Family Health History**

[ ]  Unknown (e.g. adopted)[ ]  No significant family history

[ ]  Mother alive [ ]  Mother deceased Age at death\_\_\_\_ Cause of death\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Father alive [ ]  Father deceased Age at death\_\_\_\_ Cause of death\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Significant family history**

|  |  |  |  |
| --- | --- | --- | --- |
|   **Condition** |  **Family member** |  **Condition** |  **Family member** |
|  [ ]  Diabetes |  |  [ ]  Breast Cancer/Prostate Cancer  |  |
|  [ ]  High Blood Pressure |  |  [ ]  Colon or other cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  [ ]  Stroke |  |  [ ]  Other Mental Illness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  [ ]  Depression |  |  [ ]  Other – Specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |