**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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |