THE STATION ON TANTI

FAMILY AND WOMEN'S CLINIC

Your Men's Health Assessment at The Station on Tanti, Family and Women's clinic

Your Men's Health assessment at The Station on Tanti provides a key set of tests and measures to give you a picture of how your current health is and a view of any future health risks.

This particular health assessment is designed specifically for you, covering important health topics relevant to men.

You'll also receive support in a variety of ways to help you to achieve any necessary changes in your lifestyle to help you to become healthier today and in the future.

Our health assessment provides you with a set of test results to help identify key health risks, backed up with guidance and coaching from our doctors and nurse.

Personal Details

Title | Mrs | Miss | Ms | Master | Mr | Dr	Family/Surname
Given Name	Preferred Name
Date of Birth | DD | MM | YYYY |	Gender | Male | Female | Trans |
Home Address	
	Postcode
Home Phone	Mobile Phone

Date of questionnaire completed:

Please tell us your main reason for having this assessment

☐ Review of health	☐ I want to improve my health
☐ I am concerned about a particular health issue	☐ Other

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Please tell us where do you feel you are currently with your health and what is your motivation to change behaviours by answering these questions:

Have you already, or do you intend to make changes to your lifestyle as part of your health assessment?

☐ Yes, I plan to make changes after my health assessment	☐ Yes, I have already made changes
☐ Would like to but not at the moment	☐ No
☐ Unsure	☐ Other

If yes, what would you want to change?

☐ Increase physical activity/exercise	☐ Improve stress management
☐ Reduce alcohol intake	☐ Lose weight
☐ Eat healthier	☐ Stop smoking
☐ Other	

On a scale of 0 to 10, how important is it for you to make these changes? (0 being not important, 10 being extremely important):

On a scale of 0 to 10, how confident are you that you can make the changes that you want to do? (0 being not important, 10 being extremely important):

What would you consider are barriers to make changes?

☐ Money	☐ Work
☐ Home	☐ Social
☐ Family	☐ Health
☐ Other:	

Current Health

Do you have any symptoms or problems in any of the following areas that you would like to discuss with us?

☐ Palpitations, rapid or irregular heart beat	☐ Burning or cramping sensation in your lower legs when walking short distances (10 mt)
☐ Chest pain/discomfort	☐ Ankle swelling
☐ Loss of vision	☐ Cough or phlegm
☐ Fatigue/Tiredness	☐ Pins and needles/numbness
☐ Dizziness/Lightheadedness	☐ Loss of appetite
☐ Nausea/Vomiting	☐ Abnormal weight loss
☐ Abdominal swelling	☐ Bloods in motions/rectal bleeding
☐ Dizziness, fainting or blackouts	☐ Pain passing urine
☐ Bladder control/urinary incontinence	☐ Hair loss/skin problems
☐ Shortness or breath or wheezing	☐ Night sweats/fever
☐ Sleep	☐ Headaches
☐ Muscle weakness	☐ Memory
☐ Indigestion/Heartburn	☐ Abdominal pain
☐ Change in bowel habit	☐ Blood in urine
☐ Excessive frequency of urination	☐ Joint or muscle pain or stiffness
☐ Back pain	☐ None of the above
☐ Other	

Current Health

Have you had any of the following?

☐ Heart surgery or procedures (coronary, bypass, STENT, pacemaker)	☐ Heart attack, angina or heart disease
☐ Heart failure	☐ Heart valve disease including aortic aneurysm
☐ Stroke or TIA (mini stroke)	☐ Diabetes
☐ Deep vein thrombosis	☐ pulmonary embolism
☐ COPD or lung emphysema	☐ Asthma
☐ Pneumonia or pleurisy	☐ Cancer
☐ Thyroid disease	☐ Muscle or nerve disease
☐ Bone or joint conditions	☐ Bone fractures or osteoporosis
☐ Accident or injuries	☐ Any operations
☐ None of the above	
☐ Other, please specify:	

Have you ever had a raised cholesterol level? | Y | N |

If yes, please provide details:

Have you ever had high blood pressure? | Y | N |

If yes, please provide details:

Please list any prescribed medicines and/or over the counter medicines that you are currently on:

Please list any health supplements or vitamins that you may be taking and the reasons for it:

Please list any allergies (medicines, foods, components, additives)

Please give details of any hospital admissions in the past 5 years:

Have any of your close relatives ever had any significant health problems including heart attack, stroke, diabetes, cancer or any inherited condition. If yes, please provide details:

Male Health

Do you regularly examine your tests | Y | N |

Do you have any of the following issues

☐ Pain, lumps or swelling in your groin or scrotum (tests bag)	☐ Feeling like you haven't emptied your bladder properly
☐ Passing urine more often than normal	☐ Weak urinary stream
☐ Straining to pass urine	☐ None of the above

If yes, please provide details:

How many times do you typically get up at the night to urinate?

Do you have sexual problems such as erectile dysfunction or premature ejaculation | Y | N |

If yes, please provide details:

Have you ever had any sexually transmitted disease | Y | N |

If yes, please provide details:

Sleep

How would you rate your quality of sleep?

□ Very poor	□ Poor
□ Average	□ Good
□ Very good	□ Excellent

Do you have difficulty getting to sleep | Y | N |
Do you wake up during the night | Y | N |
Do you wake up feeling refreshed | Y | N |

On average how many hours do you sleep at night?

Nutrition

How often do you skip breakfast in an average week?

How often do you eat fried foods, takeaways or eat out in an average week?

How many times do you eat sugary foods or drinks in an average week (for e.g. biscuits, cakes, chocolates, soft drinks, energy drinks etc)?

How many times do you eat processed meat each week (for e.g. sausages, bacon, salami, pies, ham)?

How many times do you eat foods containing full dairy produce each week?

How many times do you eat oily fish each week (for e.g. sardines, salmon or trout)?

How many portions of vegetables or salad (excluding potatoes) do you eat each day?

How many portions of fruit do you eat each day?

How many servings of high fibre foods do you eat each day (for e.g. wholemeal bread, root vegetables like carrots and potatoes, bran, nuts, cereals, fruit, beans, oats)?

How many caffeinated drinks do you drink each day?

Do you follow a special diet, eat or avoid certain foods for health or other reasons?

Are you currently following a weight loss diet | Y | N |

Physical Activity

The next few questions are in relation to physical activity.

What is the total amount of time in minutes, during a typical week, that you are physically active at a moderate intensity for (for e.g. brisk walking, gentle cycling, gentle swimming that lasts longer than 10 minutes)?

What is the total amount of time in minutes, during a typical week, that you are physically active at a vigorous intensity for (for e.g. running, fast cycling, competitive sport, aerobics or fitness class)?

What physical activities or sports do you practice?

How many days per week do you usually exercise or are physically active?

Do you perform muscle strengthening exercises at least twice a week (for e.g. exercises using body weight against resistance) | Y | N |

Does your daily routine involve you sitting for prolonged periods of time | Y | N | Total hours:
Please provide details:

Alcohol and Smoking

The next few questions are in relation to the number of units of alcohol you may drink and tobacco products

How many units of alcohol do you drink in a typical week?

Do you smoke or use other nicotine containing products | Y | N |
Please provide details:

Psychological Well Being

Over the last month, have you felt under excessive stress or strain | Y | N |

Do you smoke or use other nicotine containing products | Y | N |
Please provide details:

Over the last 2 weeks, how often have you been bothered by the following problems?

Feeling nervous anxious or on edge:

☐ Not at all	☐ Several days
☐ More than half the days	☐ Nearly every day

Not being able to stop or control worrying:

☐ Not at all	☐ Several days
☐ More than half the days	☐ Nearly every day

Little interest or pleasure doing things:

☐ Not at all	☐ Several days
☐ More than half the days	☐ Nearly every day

Feeling down, depressed or hopeless:

☐ Not at all	☐ Several days
☐ More than half the days	☐ Nearly every day

Work

Are you currently working?

☐ Full Time	☐ Part Time
☐ Retired	☐ Homemaker
☐ Student	☐ Un-Employed
☐ Other	
Occupation	
How many hours a week on average do you work	
How do you get to work	
How long does your journey to work take	
Do you have a lunch break? If yes, how much time?	
Do you care for any dependent or relative | Y | N | If yes, please provide details:	
How many days off work due to sickness have you had over the last 12 months	