45-49 year old Health Assessment SNAP SHOT questionnaire

This questionnaire is designed to collect important information about you prior to your health assessment, this will allow you time to answer important questions and ask your family about their medical history and conditions you could be at risk of in the future.

Family history (please circle or explain)

Are your biological parents still alive? I'm adopted / unknown

Mother: Yes / No Age passed:_____Cause (if known):_____

History of: Diabetes / hypertension / heart disease / stroke / bowel cancer / breast cancer /depression (please circle)

Father: Yes / No Age passed:_____ Cause (if known):_____

History of: Diabetes / hypertension / heart disease / stroke / bowel cancer / breast cancer /depression

Other family members and significant history:

Social history (please circle or explain)

Relationship status: married / de facto / single / other:_____

Sexual orientation: heterosexual / homosexual / bisexual / other:_____

Accommodation: own home / rental / other:_____

Occupants in dwelling: alone / partner / parents / children / other:_____

Who cares for you: Self / other:_____

Are you a carer for someone: Yes / No Who:_____

Do you drive: Yes / No other transportation options:_____

Is your home safe from internal and external threats: Yes / No

Employment (please circle or explain)

Current employment role:_____full-time / part-time / casual / self-employed

Duties:_____

Employment in 30's role:_____full-time / part-time / casual / self-employed

Duties:_____

Employment in 20's role:_____full-time / part-time / casual / self-employed

Duties:_____

What is important to you and what are you worried about (please circle or explain)

Cancer screening: bowel / breast / cervical / prostate / lung / skin / other:_____

Cardiovascular disease: blood pressure / cholesterol / heart attack / stroke / other:_____

Mental health: depression / anxiety / stress / sleep / energy / motivation / other:_____

Other:_____

What does good health mean to you:_____

How important is good health: very important / important / neutral / not important / very unimportant

How do you rate your health: excellent / good / neutral / not so good / needs to be improved

Smoking (if you have NEVER smoke/vaped skip this question)

Smoking type: Cigarettes / cigars / vape Number per day:_____ Number per week:_____

Year started:_____ Year stopped:_____

Reason for starting:_____ Reason for quitting:_____

Quitting method: patches / gum / inhaler / other:_____ Barriers to quitting:_____

_____

Previous smoking in your 30's

Smoking type: Cigarettes / cigars / vape Number per day:_____ Number per week:_____

Year started:_____ Year stopped:_____

Reason for starting:_____ Reason for quitting:_____

Quitting method: patches / gum / inhaler / other:_____ Barriers to quitting:_____

_____

Previous smoking in your 20's

Smoking type: Cigarettes / cigars / vape Number per day:_____ Number per week:_____

Year started:_____ Year stopped:_____

Reason for starting:_____ Reason for quitting:_____

Quitting method: patches / gum / inhaler / other:_____ Barriers to quitting:_____

_____

Nutrition (fruit, vegetables, dairy, protein, carbohydrates, sugar, fat, water, flavours)

My current diet consists of: (please describe common foods/liquids, quantity/size and frequency)

Breakfast:_____

Lunch:_____

Dinner:_____

Fluids:_____

Snacks:_____

Barriers to nutrition: time / motivation / finances / family / other:_____

Previous nutrition in your 30's

Breakfast:_____

Lunch:_____

Dinner:_____

Fluids:_____

Snacks:_____

Barriers to nutrition: time / motivation / finances / family / other:_____

Previous nutrition in your 20's

Breakfast:_____

Lunch:_____

Dinner:_____

Fluids:_____

Snacks:_____

Barriers to nutrition: time / motivation / finances / family / other:_____

Alcohol (if you have NEVER consumed alcohol skip this question)

Alcohol type: beer / wine / spirits / other:_____Number per day:_____Number per week:_____

When you have a big day / night how many STD drinks do you have:____How often do you have big days/nights:_____

I usually drink when:_____I don't like to drink when:_____

Age started:_____Age stopped:_____reason for stopping:_____

_____

Previous alcohol in your 30's

Alcohol type: beer / wine / spirits / other:_____Number per day:_____Number per week:_____

When you have a big day / night how many STD drinks do you have:____How often do you have big days/nights:_____

I usually drink when:_____I don't like to drink when:_____

Age started:_____Age stopped:_____reason for stopping:_____

_____

Previous alcohol in your 20's

Alcohol type: beer / wine / spirits / other:_____Number per day:_____Number per week:_____

When you have a big day / night how many STD drinks do you have:____How often do you have big days/nights:_____

I usually drink when:_____I don't like to drink when:_____

Age started:_____Age stopped:_____reason for stopping:_____

_____

Physical Activity (30 continuous minutes per day, 5 days a week or 2.5 hours a week)

My current physical activity consists of: (please describe walking / swimming / gym / Pilates / sports)

Physical activity type:_____minutes per activity:_____times per week:_____

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Physical activity type:_____minutes per activity:_____times per week:_____

Physical activity type:_____minutes per activity:_____times per week:_____

Physical activity type:_____minutes per activity:_____times per week:_____

Barriers to physical activity: time / motivation / finances / family / injuries / other:_____

Previous physical activity in your 30's

Physical activity type:_____minutes per activity:_____times per week:_____

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Physical activity type:_____minutes per activity:_____times per week:_____

Barriers to physical activity: time / motivation / finances / family / injuries / other:_____

Previous physical activity in your 20's

Physical activity type:_____minutes per activity:_____times per week:_____

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Barriers to physical activity: time / motivation / finances / family / injuries / other:_____