Place label here

## Profile: Health Behaviours

If question is irrelevant or information not known, write Not Applicable or NA

**SFF CODE:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Smoking | | | | **Prostate Screening Test (50 and over)** | | ⭘ N/A (under 50) |
| ⭘ Never smoked | | | | PSA Blood Test ⭘ Yes Year ⭘ No | | |
| ⭘ Has quit smoking | | | | Digital Rectum Examination ⭘ Yes Year ⭘ No | | |
| If quit, record when: Year \_\_\_\_\_\_\_\_\_\_\_\_ | | | |  | | |
| ⭘ Currently smoke | | | |  | | |
|  | | | | Respiratory | | |
| **Alcohol** | | | | Do you currently have a cold? | | |
| How often do you have a drink containing alcohol? | | | | ⭘ Yes | ⭘ No | |
| ⭘ Never - *if never, proceed to Continence* | | | | Over the **last month** I have had: | | |
| ⭘ Monthly to 3 monthly | | | | ⭘ Nasal congestion | ⭘ Cough with phlegm (sputum) | |
| ⭘ Once a week | | | | ⭘ Frequent cough | ⭘ Cough at end of work day | |
| ⭘ 2 to 4 times per week | | | | ⭘ Wheezy breathing | ⭘ Shortness of breath | |
| ⭘ 5+ per week | | | | ⭘ Morning cough | ⭘ Chest pain or tightness | |
|  | | | |  | ⭘ None of the above | |
| How often do you have more than; | | | |  | | |
| - Males: 6 standard drinks on 1 occasion? | | | | How often does shortness of breath prevent you from doing | | |
| - Females: 4 standard drinks on 1 occasion? | | | | something that you think you ought to be able to do? | | |
| ⭘ Never | | | | ⭘ A few times a year | ⭘ Daily | |
| ⭘ Monthly to 3 monthly | | | | ⭘ Monthly | ⭘ Never | |
| ⭘ Once a week | | | | ⭘ Weekly | | |
| ⭘ 2 to 4 times per week | | | |  | | |
| ⭘ 5+ per week | | | | I snore at night: | | |
|  | | | | ⭘ Every night | ⭘ Rarely | |
| How many standard drinks do you have | | | | ⭘ Sometimes | ⭘ Never | |
| on a typical day when you are drinking? | | | |  | | |
| ⭘ 1 to 2 | | | | When I wake in the morning I feel refreshed: | | |
| ⭘ 3 to 4 | | | | ⭘ Always | ⭘ Rarely | |
| ⭘ 5 to 6 | | | | ⭘ Sometimes | ⭘ Never | |
| ⭘ 7 to 8 | | | |  | | |
| ⭘ 8+ per day | | | | I experience breathing difficulties, cough, wheezy breathing or | | |
|  | | | | chest tightness after working with livestock, dust, chemicals or | | |
| **Continence** | | | | grains: | | |
| My water works bother me | | | | ⭘ Always | ⭘ Rarely | |
| ⭘ Monthly | | | | ⭘ Sometimes | ⭘ Never | |
| ⭘ Weekly | | | |  | | |
| ⭘ Daily | | | | Over the **last year** I have had: | | |
| ⭘ Never | | | | * Nasal congestion * Frequent cough | * Cough with phlegm ( sputum) * Cough at end of work day | |
| **Breast Screen** | | | | ⭘ Wheezy breathing | ⭘ Shortness of breath | |
| ⭘ Yes | | | ⭘ No | ⭘ Morning cough | ⭘ Chest pain or tightness | |
| If yes, record when: Year \_\_\_\_\_\_\_\_\_\_\_\_ | | | |  | ⭘ None of the above | |
|  | | | |  |  | |
| **Pap Smear** | | | | Physical Activity | | |
| ⭘ Yes | ⭘ No | ⭘ N/A (hysterectomy) | | Would you accumulate 30 minutes or more of moderate | | |
| If yes, record when: Year \_\_\_\_\_\_\_\_\_\_\_\_ | | | | intensity physical activity on most days of the week? | | |
|  | | |  | ⭘ Yes | ⭘ No | |

##### Health Professional Use Only

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| SFF HP Name: | | I have read and discussed responses with participant | | |
|  |  |  |  |  |
| Sign: | | Date: | Contact Number: | |

## Profile: Health Conditions

If question is irrelevant or information not known, write Not Applicable or NA

Place label here

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Overall Health | Vision | | | | Hearing | | | |
| In general, how would you say | Have you had a vision test? | | | | How is your hearing? | | | |
| your health is? | ⭘ Yes | | | Year \_\_\_\_\_\_\_\_\_ | ⭘ Good hearing both ears | | | |
| ⭘ Excellent | ⭘ No | | | | ⭘ Difficulty hearing with one ear | | | |
| ⭘ Very Good |  | | | | ⭘ A little trouble hearing both ears | | | |
| ⭘ Good | Do you wear glasses/contact lens? | | | | ⭘ A lot of trouble hearing both ears | | | |
| ⭘ Fair | ⭘ Yes | | | ⭘ No | ⭘ Deaf in both ears | | | |
| ⭘ Poor |  | | | |  | | | |
|  | How is your eyesight for reading? | | | | Do you wear a hearing aid? | | | |
| How much bodily pain have you | *- without visual aid* | | | | ⭘ Yes | | | ⭘ No |
| had during the past 4 weeks? | ⭘ Excellent | | | ⭘ Fair |  | | | |
| ⭘ None | ⭘ Good | | | ⭘ Poor |  | | | |
| ⭘ Very Mild |  | | | | Falls | | | |
| ⭘ Moderate | How is your long distance eyesight? | | | |  | | | |
| ⭘ Severe | *- without visual aid* | | | | Have you had a fall inside/outside | | | |
| ⭘ Very Severe | ⭘ Excellent | | | ⭘ Fair | the home in the past 6 months? | | | |
|  | ⭘ Good | | | ⭘ Poor | ⭘ Yes | number of falls \_\_\_\_\_\_\_\_ | | |
| How much did your health interfere |  | | | | ⭘ No | | | |
| with your normal activities (outside |  | | | |  | | | |
| and/or inside the home) during the | **Bowel Screening** | | | | **Dental** | | | |
| past 4 weeks? |  | | | |  | | | |
| ⭘ Not at all | Have you had a bowel cancer | | | | Have you had a dental check-up in | | | |
| ⭘ Slightly | screen test? (i.e. faecal blood test) | | | | the last 3 years? | | | |
| ⭘ Moderately | ⭘ Yes | Year \_\_\_\_\_\_\_\_\_ | | | ⭘Yes | | Year \_\_\_\_\_\_\_\_ | |
| ⭘ Quite a bit | ⭘ No | | | | ⭘ No | | | |
| **Health Conditions**  **-** *include all issues/ conditions that you have experienced or currently experiencing* | | | | | | | | |
| 1. | | | | | | | | |
| 2. | | | | | | | | |
| 3. | | | | | | | | |
| 4. | | | | | | | | |
| 5. | | | | | | | | |
|  | | | | | | | | |
| **Current Medications** *(include prescriptions, over-the-counter, alternative products and pain killers)* | | | | | | | | |
| 1. | | | 5. | | | | | |
| 2. | | | 6. | | | | | |
| 3. | | | 7. | | | | | |
| 4. | | | 8. | | | | | |

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| Sign: | | Date: | Contact Number: | |