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. |

##### Health Professional Use Only

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