| Difficulty swallowing | Change in bowel habits | Blood in the urine | Pain when passing urine | Getting up more than once in the night to pass urine | Losing urine | Sexual function or desire | Sexually transmitted infections | Depression / anxiety | Maintaining relationships | Anger | Violence | Unexplained weight loss | Change in mood | Testicular check |

Overall, how happy are with your life at present

1 2 3 4 5 6 7 8 9 10
(Poor) (Very happy)

Do you experience constant worrying thoughts

☐ Yes  ☐ No

How is your memory concentration?

1 2 3 4 5 6 7 8 9 10
(Poor) (Excellent)

How do you see the future?

1 2 3 4 5 6 7 8 9 10
(Not so good) (Excellent)

What type of support do you have?

☐ Family  ☐ Community group
☐ Friends  ☐ Church

Copies of this pamphlet are available from Hawkesbury District Health Service
Ph: (02) 45605714

Some content was sourced from resources of the Men’s Health Unit, Northern Sydney Central Coast Health.

Photos supplied by David Mapletoft
Please tick
My last visit to a GP was:
☐ In the past 3 months ☐ 6 - 12 months ago
☐ 1 - 2 years ago ☐ 3 - 5 years ago
☐ More than 5 years ago

When did you last have a full medical check-up?
☐ In the past 3 months ☐ 6 - 12 months ago
☐ 1 - 2 years ago ☐ 3 - 5 years ago
☐ More than 5 years ago ☐ Never

Relationships and Family
What is your current relationship status?
☐ Married ☐ Separated ☐ Defacto/partner
☐ Single ☐ Girlfriend ☐ Divorced
☐ Never Married ☐ Same sex partner

Health Behaviours
Do you smoke?
☐ Yes ☐ No ☐ Ex-smoker ☐ Never
If yes, how many per day_______________

How many days of the week do you usually drink alcohol?
☐ Never ☐ Less than monthly ☐ 1 - 2 days a month
☐ 1-2 days a week ☐ 3 - 4 days a week
☐ 5 - 6 days a week ☐ Every day

On any one day when you drink alcohol, how many standard drinks (middy of beer, 1 glass of wine, 1 nip of spirits) do you usually have?
☐ 1 or 2 ☐ 3 to 5 ☐ 6 to 9 ☐ 10 or more

Do you use any of the following?
☐ Marijuana ☐ Amphetamines (speed, ice, crystal)
☐ Ecstasy ☐ Steroids ☐ Heroin
☐ GHB/GBH ☐ Other........... ☐ Not applicable

How often do you engage in exercise or activity (eg brisk walking long enough to work up a sweat) for at least 30 minutes at a time?
☐ 3 or more times a week ☐ 1 - 2 times a week
☐ Seldom ☐ Never

Health Concerns
Are you concerned about any of the following?
☐ Smoking ☐ Drinking ☐ Loneliness
☐ Eating habits ☐ Weight ☐ Work environment
☐ Lack of exercise ☐ Stress ☐ Depression
☐ Family relationships ☐ Anxiety ☐ Parenting
☐ Drug Use (legal/illegal) ☐ Finances ☐ Family matters
☐ Aggressive feelings ☐ Sexual health
☐ Other__________________

Do you have problems sleeping, e.g.: not getting enough, getting to and staying asleep, sleeping too much?
☐ Yes ☐ No ☐ Not sure

Do you take medication to help you sleep?
☐ Yes ☐ No

Have you ever had a cholesterol test?
☐ Yes ☐ No ☐ Not sure

Have you had a tetanus / diphtheria injection in the past 10 years?
☐ Yes ☐ No ☐ Not sure

Are you taking any prescribed medications? If so, which ones? __________________________________

Are you taking any complementary medicines (e.g.: vitamin supplements, chiropractic, homeopathy.)?
☐ Yes ☐ No

Do you have any 'concern's or problems regarding...
Please tick if yes

<table>
<thead>
<tr>
<th>Eyes/vision</th>
<th>Hearing / Ears</th>
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<tbody>
<tr>
<td>Mouth, Teeth, Gums</td>
<td></td>
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<tr>
<td>Skin - eg: rashes, lumps, moles</td>
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<tr>
<td>Soreness or lumps under the arms, groin or neck</td>
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<tr>
<td>Breathing difficulties</td>
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<td>Cough/phlegm</td>
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<td>Asthma</td>
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<td>Bronchitis</td>
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<td>Headaches</td>
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<td>Muscles, Joint, Bone pain or stiffness</td>
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<td>Joints</td>
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<td>Bones</td>
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<td>Sleeping difficulties</td>
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<td>Feeling stressed</td>
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<td>Tiredness</td>
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<td>Irritability</td>
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<td>Lack of energy</td>
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<td>Chest Pain</td>
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<td>Palpitations/ racing heart rate / shortness of breath</td>
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<td>High blood pressure</td>
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<td>Poor circulation</td>
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<tr>
<td>Diabetes (Family history/Heart disease)</td>
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<tr>
<td>Weight (recent gain or loss)</td>
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<tr>
<td>Appetite, digestion, heartburn</td>
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