 **Elmwood Health Screening** **(Male)**

Section 1: Personal Information

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Visit today :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had a Health Screen here before?** Yes No

**If so, when?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have Private Health Insurance ?** Yes No

**If Yes, which Provider do you use?**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Section 2: Medical History

 Cardiovascular/Neurological

Please indicate if you have been diagnosed with any of the following conditions, or have had any of the following procedures:

**High blood pressure:**  Yes No

**High cholesterol:** Yes No

**Angina:** Yes No

**Heart attack:**  Yes No

**Bypass surgery:** Yes No

**Coronary stent:** Yes No

**Peripheral vascular disease:** Yes No

**Stroke/TIA (mini-stroke):** Yes No

*Notes for Physician:*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Please indicate if you have been diagnosed with any of the following conditions, or have had any of the following procedures:

 Respiratory

**Asthma:** Yes No

**COPD/Emphysema:**  Yes No

 General

**Thyroid disease:**  Yes No

**Liver disease:**  Yes No

**Diabetes:** Yes No

**Anaemia/blood disorders:**  Yes No

**Cancer:** Yes No

**Eye disease:**  Yes No

**Visual impairment**

(not including long/short sight requiring glasses): Yes No

 Hearing

**Do you wear a hearing aid(s)?**  Yes No

**Do you have any hearing impairment?** Yes No

**Do you have other ear trouble(e.g. wax or infections)?**Yes No

**Have you had a previous hearing test?**  Yes No

 Gastrointestinal

**Stomach ulcer disease:** Yes No

**Crohn’s/ulcerative colitis:** Yes No

**Irritable bowel syndrome:**  Yes No

Have you had a previous **colonoscopy**?

If Yes, please state date performed and result:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Kidney

**Chronic kidney disease:** Yes No

**Kidney stones:**  Yes No

**Recurrent kidney/ bladder infection**: Yes No

Other medical conditions or issues not listed (please specify):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you answered Yes to any of the above questions, please explain briefly:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide details of any surgical procedures requiring a General Anaesthetic:

(e.g Tonsils/Appendix etc)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications

**Do you take any medications?** Yes No

If Yes, please list all medications (including prescribed/over the counter/herbal supplements):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies

**Do you have any serious allergies:** Yes No

Details

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Notes for Physician:*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you know if any of your immediate\* family suffer(ed) from:

Section 3: Family History

\* This includes blood relatives (i.e. **father, mother, brother, sister, children**)

Relationship/Age

**High cholesterol:** Yes No Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_\_

**High blood pressure:**  Yes No Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_\_

**Heart diseased under 60 years:** Yes No Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_\_

**Stroke/TIA (mini-stroke):** Yes No Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_\_

**Haemachromatosis:**  Yes No Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_\_

**Cancer** : Yes No Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_\_

**Diabetes**: Yes No Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_\_

**Other conditions (please specify):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Section 4: General Lifestyle

Smoking *(please circle)*

**Smoker**  **Ex-smoker** **Non-smoker**

Year started smoking: \_\_\_\_\_\_\_\_\_\_\_\_\_ Year stopped smoking \_\_\_\_\_\_\_\_\_\_\_\_\_

Number of cigarettes: \_\_\_\_\_\_ or cigars: \_\_\_\_\_\_ or pipe smoked per day: \_\_\_\_\_\_

E-cigarettes (Vaping) : Yes No

Alcohol intake *(please circle)*

**Do you drink alcohol?**  Yes No

**If you answered Yes to the above question please indicate how many of each of the following you would consume in an average week?**

Pints:

Beer/cider/stout \_\_\_\_\_\_ Glasses of wine: \_\_\_\_\_\_ Measure of spirits (1 shot): \_\_\_\_\_\_

**How many days of the week do you have six or more standard drinks? *(Please circle)***

Never Less than monthly Monthly Weekly Daily or almost daily

*Note one standard drink is a pub measure of spirits (35.5ml), a small glass of wine* (12.5%vol) or half a pint

 Drug use *(please circle)*

**Drug use?** Yes No

(including illegal drug use and the use of prescription drugs other than as prescribed):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever felt that you ought to cut down on your drinking or drug use?** Yes No

**Have people annoyed you by criticising your drinking or drug use?** Yes No

**Have you ever felt bad or guilty about your drinking or drug use?** Yes No

**Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover?** Yes No

*Notes for Physician:*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical activity/exercise *(please circle)*

**How often do you exercise for 30 minutes or more outside of your normal work or daily responsibilities** Note: this would be exercise that moderately increases your breathing and heart rate, and makes you sweat (such as brisk walking, cycling, swimming, jogging, aerobics or climbing stairs).

Seldom/never Less than once a week 1-2 days a week

3-4 days a week 5-6 days a week Daily

**What type of exercise do you take?**

Walking Running Golf Gym Other

**If you are currently working, how much hard physical work is required on your job?** *(Please circle)*

Great deal Moderate amount Little None

Stress *(please circle)*

**On scale of 1-10 how stressed are you? 1 = Not stressed 10 = Extremely stressed**

1 2 3 4 5 6 7 8 9 10

**Over the last 2 weeks how often have you been bothered by any of the following problems? *(****Please tick relevant box)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Not at all | Several days | More than half the days | Nearly every day |
| Little interest or pleasure in doing things |  |  |  |  |
| Feeling down, depressed or hopeless |  |  |  |  |
| Trouble falling or staying asleep, or sleeping too much |  |  |  |  |

Dietary Information *(please tick)*

**How many portions/servings of each of the following foods to do you eat on average per day?**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Food type \* Note a portion is usually a small fist sized amount | Less than every day | Very small amounts | 1 portion | 2 portions | 3 portions | 4 portions | 5 portions or greater |
| Vegetables, salad or fruit |  |  |  |  |  |  |  |
| Wholemeal cereals, breads, potatoes, pasta or rice |  |  |  |  |  |  |  |
| Milk, yoghurt or cheese |  |  |  |  |  |  |  |
| Meat, poultry, fish, eggs, beans or nuts |  |  |  |  |  |  |  |
| Fats, spreads or oils |  |  |  |  |  |  |  |
| Foods and drinks high in fats, sugar or salt |  |  |  |  |  |  |  |

**How many glasses/cups (200ml) of water or other fluids do you drink per day**? \_\_\_\_\_

Snoring *(please circle)*

**As far as you are aware do you snore?**  Yes No

**If yes, has it impacted on anyone living in your household?**  Yes No

Section 5: Male Wellbeing

**Do you have lumps or swelling in your testicular region?**  Yes No

If Yes, please give details

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you examine your testicles regularly (once a month)?**  Yes No

**Have you ever had a prostate screening blood test (PSA)?**  Yes No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever had a prostate examination by a Doctor performed)?** Yes No

If Yes, please state date performed and result:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has your bowel habit changed in any way over > 6 weeks ?** Yes No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever noticed blood or mucus when you**

**pass a bowel motion?**  Yes No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any issues regarding sexual issues you wish to discuss?**

**(e.g. concerns for STIs, erectile dysfunction, lower libido, etc.).** Yes No

**Do you have any difficulties passing urine?**  Yes No

**Do you get up at night to pass urine – if so how many times ?** Yes No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever noticed any blood in your urine?**  Yes No

Assessment History

Section 6: Office Use Only

**Reviewed Patient questionnaire:**  Yes

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Examination

**Blood Pressure** \_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_

**Blood Pressure medication**  Yes No

**Medication taken today** Yes No N/A

**Height** \_\_\_\_\_\_\_\_\_\_\_\_\_\_cm  **Weight** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ kgs **Waist** \_\_\_\_\_\_\_\_\_\_\_\_\_\_cm

**BMI :**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pulse**: \_\_\_\_\_ **Regular/Irregular**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

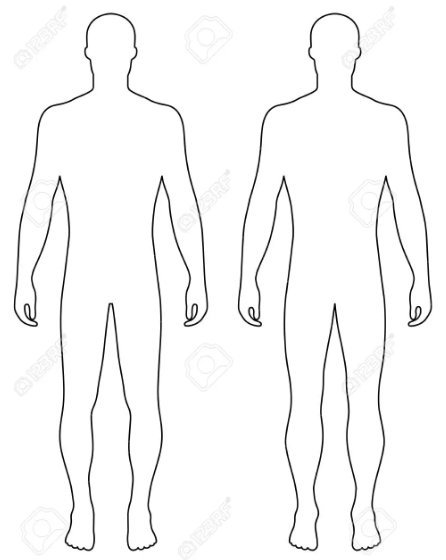
**Heart Sounds:** 1+2=0 Yes/No

**Murmurs:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chest exam: Normal Abnormal

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Skin exam**: Normal Abnormal

**Anterior****Posterior**

**Abdominal examination:** Normal Abnormal

**Musculo-skeletal examination:**  Normal Abnormal

**Breast exam:** Normal Abnormal

**Testicular exam/Prostate If appropriate :** Normal Abnormal

**ECG If required** Yes No

Results attached: Number of attempts:

Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dexa scan – referral**  Yes No

Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **CT Coronary calcium score – referral** Yes No

Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Blood Test**

**Has person fasted (8 hours)?**

|  |  |
| --- | --- |
|  | Tick if completed |
| Full blood count |  |
| Bone profile |  |
| Liver function |  |
| Total lipid profile (cholesterol and Triglycerides, HDL and LDL profile) |  |
| Fasting blood sugar (Diabetes) |  |
| Thyroid function testing |  |
| Kidney function |  |
| Vitamin B12 and folate |  |
| Vitamin D levels |  |
| Urine test for diabetes, infection and kidney disease |  |
| Coeliac if appropriate |  |
| STI |  |
| Other Test |  |

**Any Specialist Referrals made?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Follow up in Part 2:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Advice:**

* To include Ischaemic Heart Disease
* Cancer prevention/awareness
* Calcium and Osteoporosis
* Skin Protection
* Any Other Issues
* Self testicular examination – Men
* Breast Check - Men
* Specific advice for that patient