

Appendix 2: Patient practice prevention questionnaire

NAME _____ DATE OF BIRTH _____

Please tick or write your response. Please answer all the questions.

Don't worry if you don't know the exact date when something was done.

Put down approximately the month and year when you think it happened.

RECALL/REMINDER

Would you be happy to be contacted if, on the basis of any of your responses it is felt to be necessary by the doctor?

yes don't know no

FAMILY HISTORY

Do you have a family history of any of the following? (Tick all that apply)

alcohol problems heart attack diabetes
 bowel cancer breast cancer

BLOOD PRESSURE

When was your blood pressure last taken?

Date _____ not sure never

LIPIDS

When were your cholesterol and triglycerides (fats in the blood) last tested?

Date _____ don't know never

SUN PROTECTION

How often do you use the following to protect yourself from the sun when outdoors?

	always	often	sometimes	rarely	never
Protective clothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sunscreen creams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SMOKING

Do you smoke?

yes no, ex-smoker → date quit _____ no

Amount per day? _____

Do you wish to quit? yes undecided no

IMMUNISATIONS

When was your last tetanus booster?

Date _____ don't know never had one

Have you had three doses of the polio vaccine (drops or injection)?

yes don't know no

FOR THOSE 65 YEARS AND OLDER

When was the last time you were immunised?

Influenza? date _____ not sure never

Pneumococcal pneumonia? date _____ not sure never

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EXERCISE

How often do you engage in any regular exercise or activity, eg, brisk walking, dancing, active gardening, long enough to work up a light sweat (at least 30 minutes)?

- 3 or more times a week 1 – 2 times a week seldom never

ALCOHOL

On how many days a week do you usually drink alcohol?

- never → non drinker
 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 a day do you drink alcohol, how many drinks do you usually have?

- 1 or 2 3 or 4 5 or 6 7 to 9 10 or more

How often when you have six or more drinks on one occasion?

- never less than monthly monthly
 weekly daily or almost daily

Do you have any concerns about your drinking?

- yes unsure don't know

MEDICATIONS

Are you taking any medication not prescribed for you by this doctor, for example, pain relievers, vitamins or minerals, tranquillisers to calm you down (eg. Valium, Serapax), laxatives, sleeping pills, cough and cold medicines or antihistamines (for allergy)? Please indicate how often you take the medication.

- | | Medication | how often do you take these |
|---|------------|-----------------------------|
| <input type="checkbox"/> yes → please specify | | |

- no

WOMEN'S HEALTH

GERMAN MEASLES

Have you ever had German measles or the German measles (rubella) vaccine?

- yes, immunised had German measles don't know no

PAP SMEAR

When was your last cervical smear (Pap) test?

- Date _____ don't know never had one not applicable
(have had a hysterectomy)

ABNORMAL PAP SMEAR

Have you had an abnormal cervical smear (Pap) in the last 5 years?

- yes don't know no

WOMEN 50 YEARS OR OLDER ONLY

When was your last mammogram (breast X-ray to detect cancer)?

- Date _____ don't know never had one

HEALTH INFORMATION

Please list any health areas about which you would like more information.
