

phn
WESTERN VICTORIA

An Australian Government Initiative



Access
Your
Supports

CHAP
QUESTIONS
FOR PATIENTS



**Initiative funded
through the
Australian
Government's
PHN Program
2025-2026**

**The doctor or nurse will ask you
questions about your health.**



You can indicate if you have the problem.



Yes

**You can indicate if you do not
have the problem.**

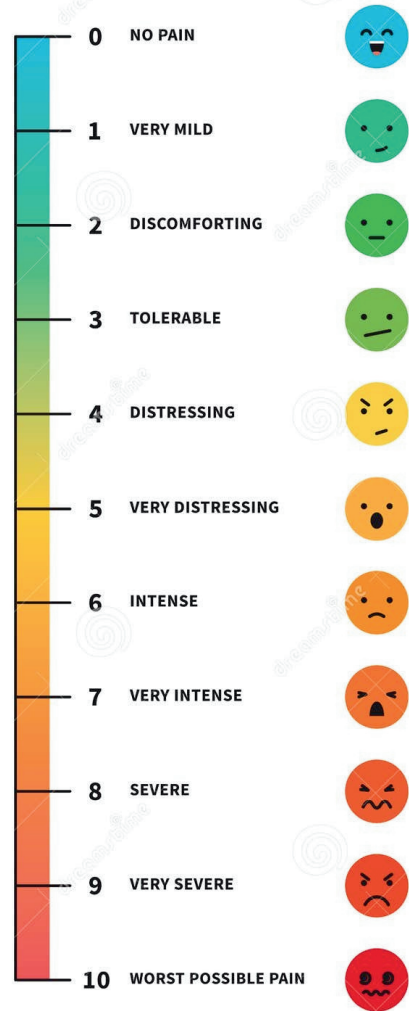


No

**You can indicate if you are unsure or
don't understand.**



Unsure



Do you cough?



**Do you cough up
blood?**



Do you have a runny nose?



Do you cough up green or yellow stuff?



**Do you get short of
breath??**



**Do you wheeze?
Does your breathing make a
squeaky noise?**



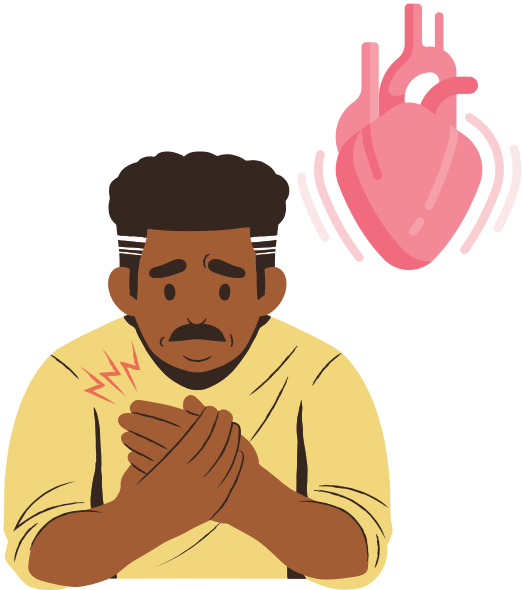
**Do you have a
heart disease that
you have had from
birth?**



**Do you have chest
pain?**



**Does your heart
race or beat
quickly?**



**Do your ankles
swell?**



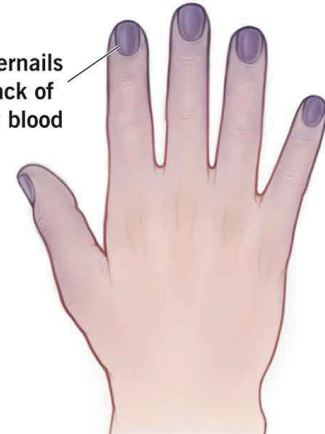
Heart

**Do you get short of
breath while lying in
bed?**



**Do you have a blue
tinge to your skin?**

Blue fingernails
due to lack of
oxygen in blood



Do you have joint pain or back pain?



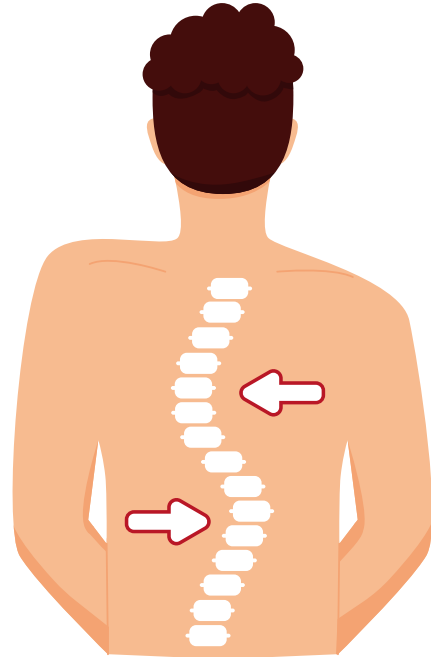
Do you have muscle pain or weakness?



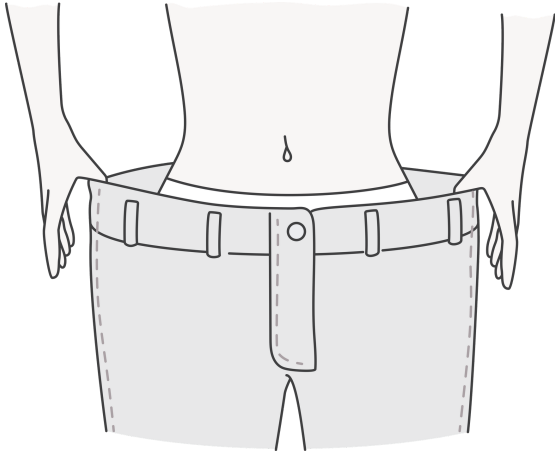
Do you use walking aids or orthotics?



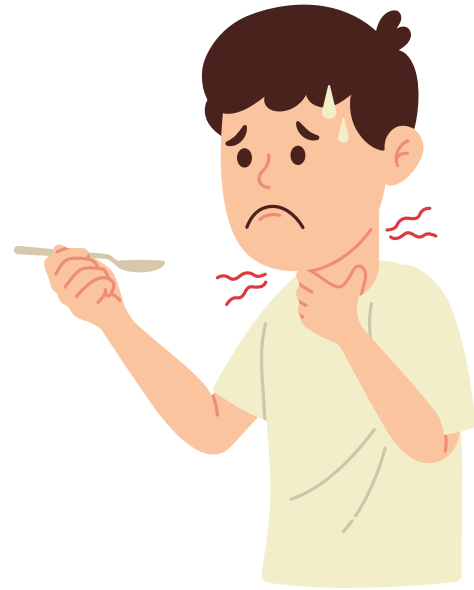
**Do you have scoliosis?
(A curved spine?)**



Have you lost weight?



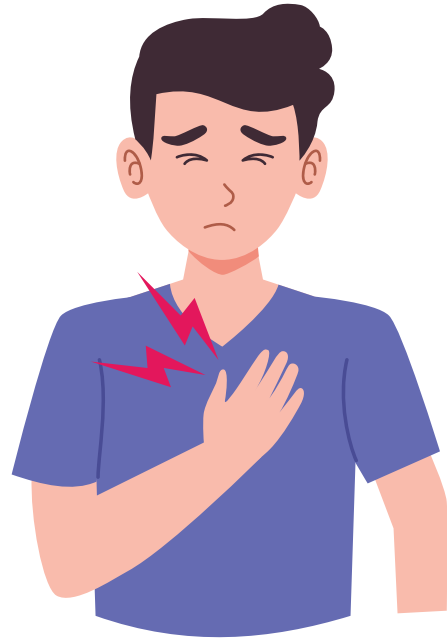
Do you have trouble swallowing?



Do you vomit?

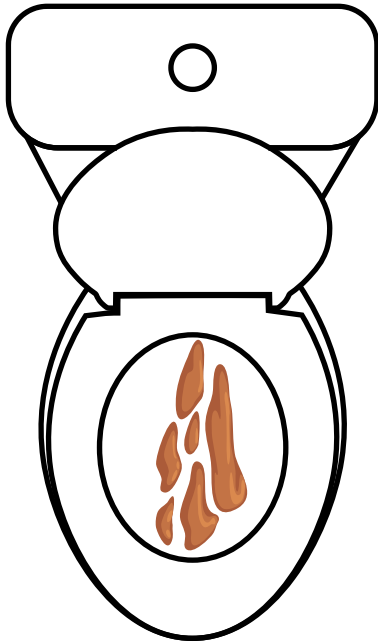


**Do you get
heartburn?**
(Pain from reflux)



Stomach & Bowel

**Do you have
diarrhoea?**
(Runny poo)

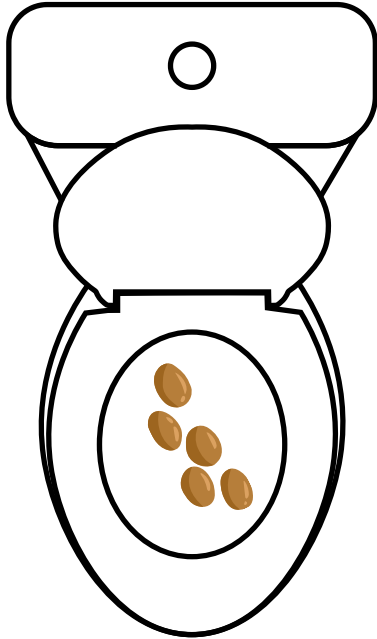


**Do you have black
poo?**



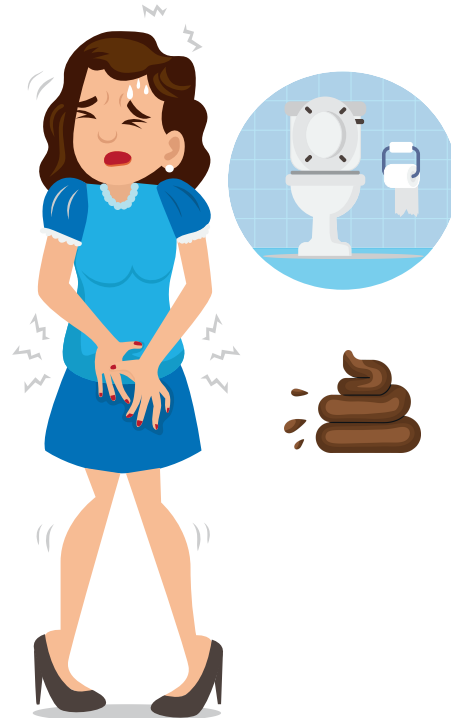
Do you get constipated?

(Hard poo that is difficult to pass)



Do you lose control of your bowel motions?

(Do you have poo accidents?)



**Do you have
stomach pain?**

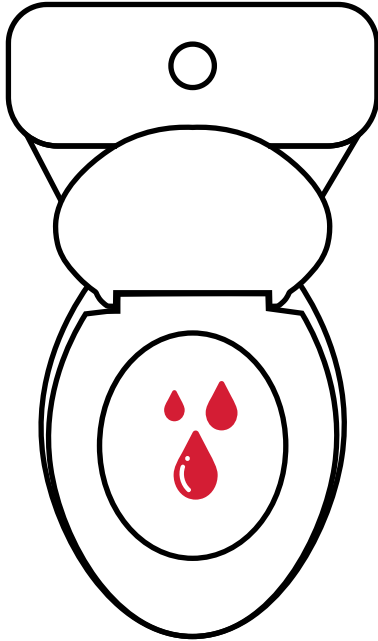


**Do you have pain
when passing urine
(wee)?**



Urinary

**Do you have blood
in your urine (wee)?**



**Can you take care of
your toileting needs?**



**Do you urinate (wee)
more than in the
past?**



**Do you have
headaches?**



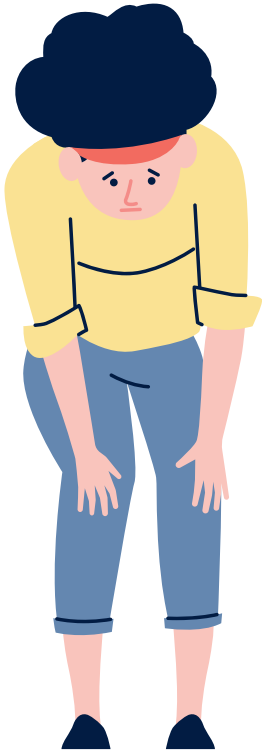
Do you faint?



Do you feel unsteady when walking?



**Do your arms or legs
become weak?**



**Do you have tingling
or strange feelings
in your skin?**



Nervous System

Do you have any skin disease or rash?



How do you react to pain?



**Do you take any
supplements that a
doctor did not
prescribe?
(Like vitamins)**



**Do you have any
allergies?**



**Do you have any
problems sleeping?**



**Do you know your
cause of your
intellectual
disability?**

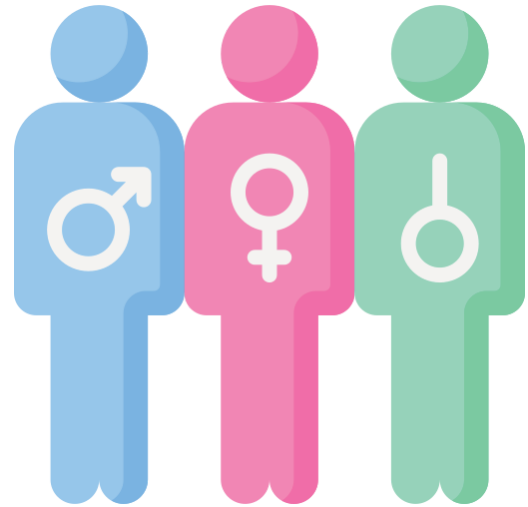


Sleep

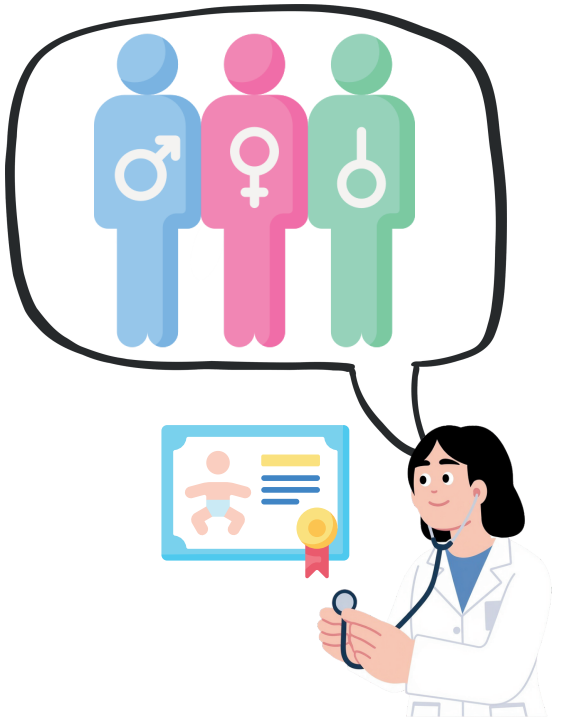
Have you ever had epileptic seizures?



What is your gender identity?
(Male, female, other?)



**What sex was listed
on your birth
certificate?**
(Male, female, other?)



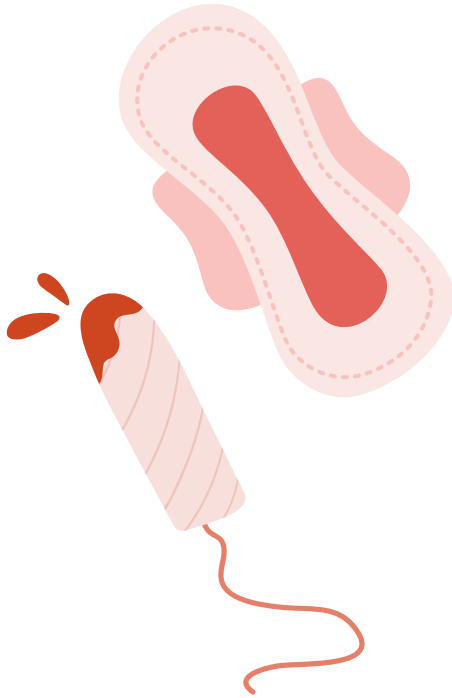
**Do you identify as
LGBTQ?**



**Have you ever been
sexually active?**



**Do you have
menstrual periods?**



**Do you care for your
periods yourself?**



**Do you use an
implanon for
contraception?**



**Do you use an IUD
for contraception?**



**Do you take the
contraceptive pill?**



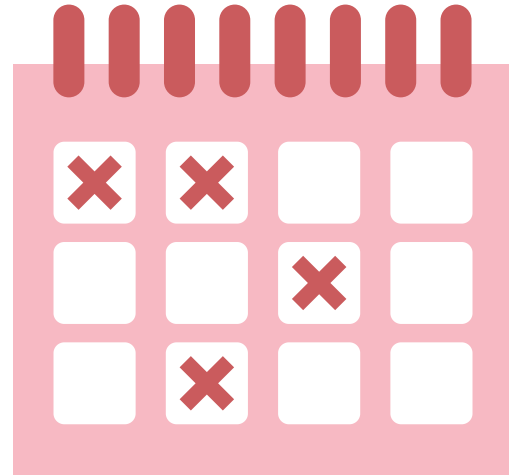
**Do you use any other
contraceptive
method?**



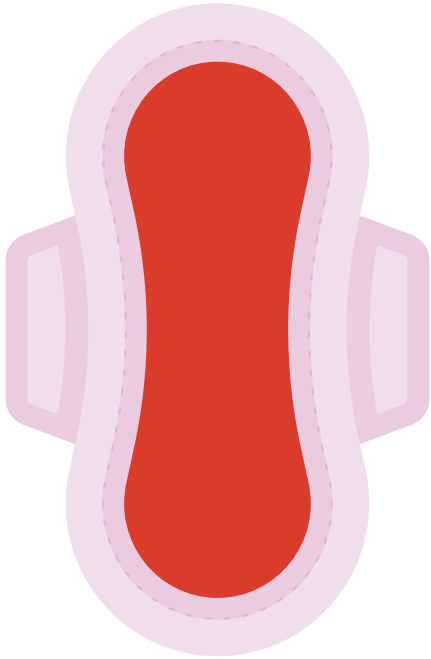
Do you have premenstrual syndrome?



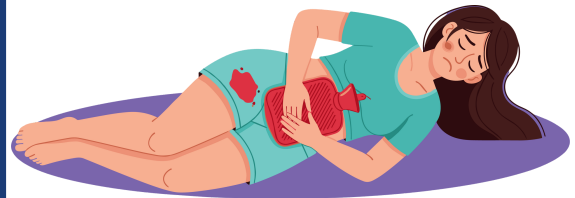
Do you have irregular periods?



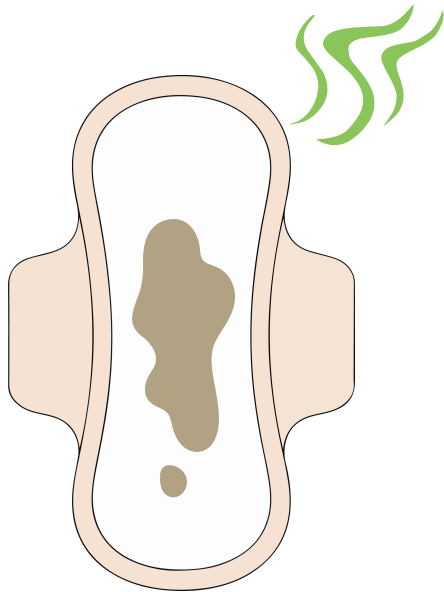
Do you have heavy periods?



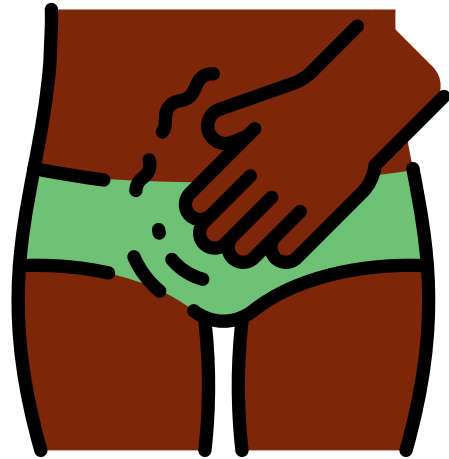
Do you have very painful periods?



**Do you have
abnormal vaginal
discharge?**



**Do you have vaginal
irritation?**
(Pain or itchiness)



**Do you have pelvic
pain?**



**Do you have
menopausal
symptoms?**
(hot flashes, irregular periods,
night sweats etc.)



**Have you had an HPV
test?**

(Test for sexual virus)



**Have you had a
cervical screening?**

(Pap smear)



**Have you had a
mammogram?**
(Breast screening)

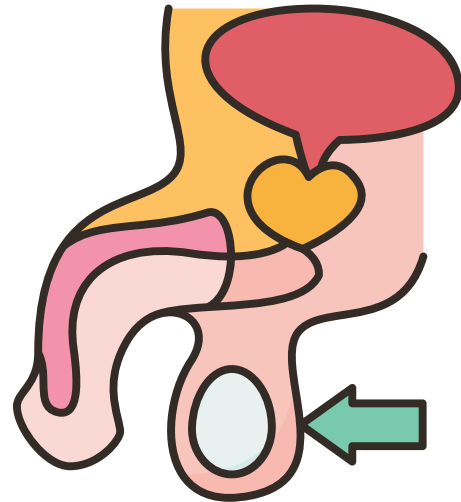


**Do you have any
problems with your
penis?**

**(Sores, scars, discharge,
itchiness, pain)**



**Are both of your
testes in the
scrotum?**



**Do you have any
erectile dysfunction?**

**(Do you have any problems
getting an erection?)**



**Do you have
behaviours of
concern?**



**Do you have any
mental health
problems?**



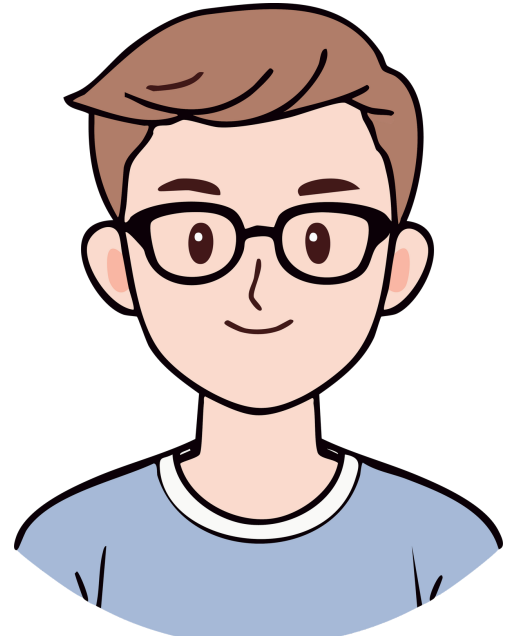
**Do you have any
problems seeing?**

**(Has anyone else said you might
have a problem?)**



**Have you ever been
prescribed glasses?**

(Do you wear them?)



**Have you had a
vision test?**



**Do you have any
problems hearing?**
(Has anyone else said you might
have a problem hearing?)



**Have you ever been
prescribed a hearing
aid?**

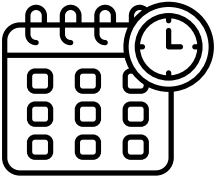
(Do you wear it?)



**Have you had a
hearing test?**



**When did you last go
to the dentist?**



**Have you had a
blood pressure
check?**



**Do you smoke
cigarettes or vape?**
(How many per day?)



**Do you drink
alcohol?**
(How many drinks do you have
in a week?)



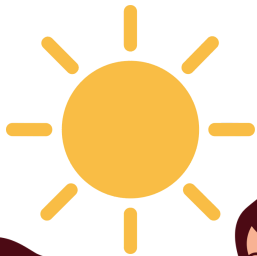
**Do you use
recreational drugs?**



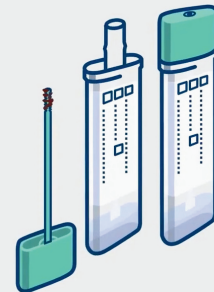
**Have you had a
thyroid test?**



**Have you had a
vitamin D test?**



**Have you had a
bowel cancer test?**



Health Promotion & Screening

**Have you had a
diabetes test?**



**Have you had a skin
check?**



**Have you noticed
any mobility changes
over time?**



**Has there been any
decline in your
ability to do things
for yourself?**

**(Has anyone else said you
might have a problem doing
things for yourself?)**



Are you physically active?



Do you have any abnormal eating behaviours?

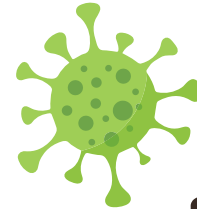


Are there any concerns about what you eat?

(Has anyone else said there might be a problem?)



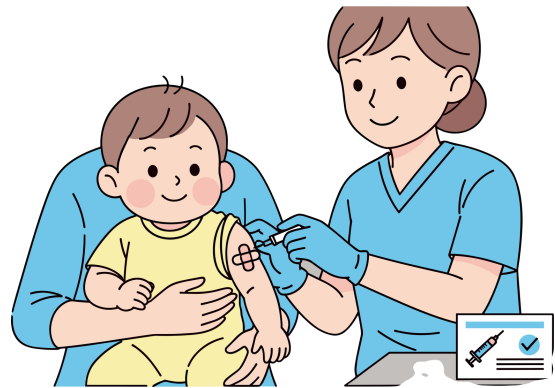
Have you had a COVID-19 vaccination?



**Have you had a flu
vaccination?**



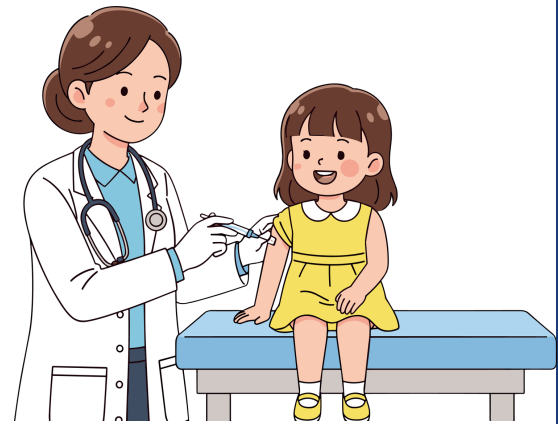
**Have you had a
tetanus/diphtheria/
pertussis
vaccination?**



**Have you had a
hepatitis A&B
vaccination?**



**Have you had a
pneumococcus
vaccination?**



**Have you had a
meningococcal
meningitis
vaccination?**



**Have you had a
measles, mumps,
rubella
vaccination?**



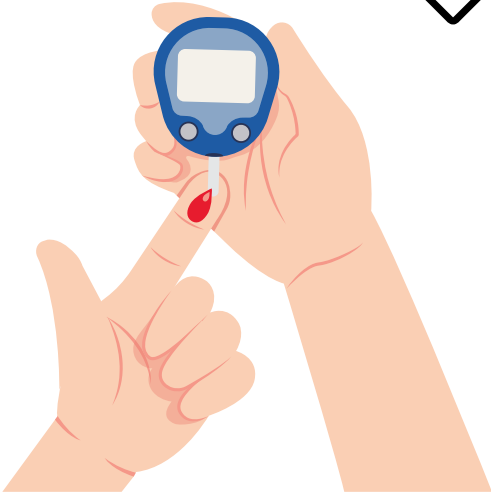
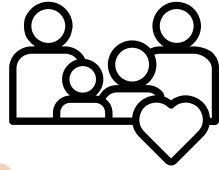
**Have you had a HPV
vaccination?**



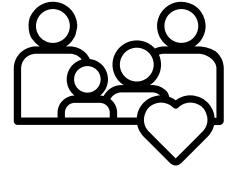
**Have you had a
shingles / herpes
zoster vaccination?**



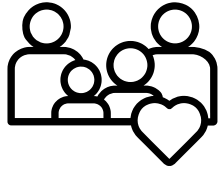
Does anyone in your family have diabetes?



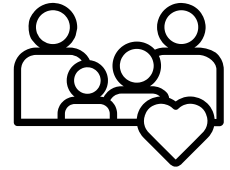
Does anyone in your family have mental health problems?



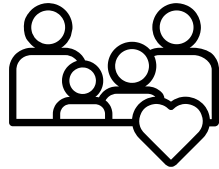
Does anyone in your family have heart disease?



Does anyone in your family have epilepsy?



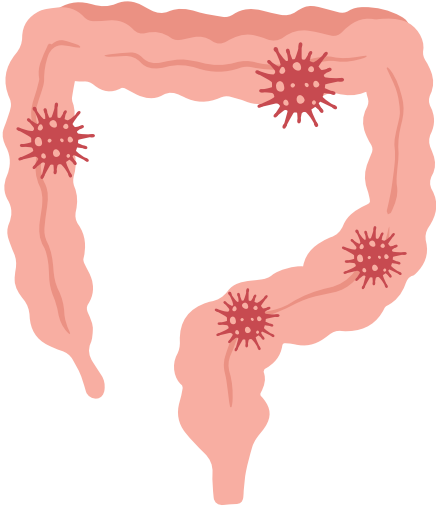
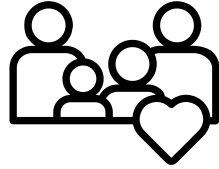
Does anyone in your family have breast cancer?



Does anyone in your family have intellectual disability?



Does anyone in your family have bowel cancer?



**Is there any other
medical information
you need to add?**



**Do you have any
other concerns?**



Your Medical History