ATTACHMENT [SL-2]

This is the attachment marked "**[SL-2]**" referred to in the witness statement of Stephen John Lillie dated 10 August 2015.

	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

Do you prefer to see a
☐male or ☐female Doctor ☐ No preference

Do you or have you used A.M.S (Aboriginal Medical Service) ☐Yes ☐ No

Overall, how would you rate your physical health? *(Please circle)*
1 2 3 4 5 6 7 8 9 10
(Poor) *(Excellent)*

Overall, how would you rate your emotional health? (mood, irritability, motivation)

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

Overall, how happy are with your life at present

1 2 3 4 5 6 7 8 9 10
(Not happy) *(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

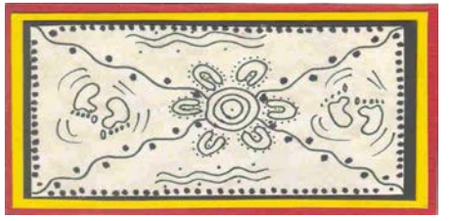
Some content was sourced from resources of the Men's Health Unit, Northern Sydney Central Coast Health.

Photos supplied by David Mapletoft

HAWKESBURY DISTRICT HEALTH SERVICE
HAWKESBURY PRIVATE HOSPITAL
catholic healthcare

MEN'S HEALTH CHECK QUESTIONNAIRE

PLEASE FILL OUT AND GIVE TO YOUR DOCTOR



Hawkesbury-Hills
Division of General Practice

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 or2 ☐ 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 *I* 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

Are you Aboriginal/Torres Strait Islander?

☐ Yes ☐ No

Do you have any 'concern's or problems regarding...?

Please tick if yes

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