

BIOLSCREEN

Sleep

The following questions ask about your sleep over the **PAST FOUR WEEKS**.

- In general, do you have problems with your sleep? Yes No
- If yes, how many nights a week do you have problems with your sleep? _____
- If yes, how long you had problems with your sleep? _____
- On average, how many hours sleep do you get each night? _____
- Does the amount of sleep you get vary each night? Yes No
- Does your sleep duration during the week differ from the weekend? Yes No
- Do you have a regular time you go to sleep each night? Yes No
- Do you have a regular time you wake up each day? Yes No
- Have you had any of the following problems with your sleep?
- | | | |
|--|-----|----|
| Difficulty getting to sleep | Yes | No |
| Waking up in the middle of the night | Yes | No |
| Waking up too early | Yes | No |
| Feeling tired and unreseted in the morning | Yes | No |
- Have you been told you snore? Yes No
- Do you struggle to stay awake during the day? Yes No
- Do you fall asleep during the day? Yes No
- Do you use your bed for things other than sleep and sex?
(e.g., watching TV, using a computer or smartphone, eating) Yes No

Nutrition

These questions ask about **HOW MANY** serves of foods you ate **YESTERDAY** and on **A TYPICAL DAY**. Write the number of serves in the boxes next to each food group.

	FOOD TYPE	YESTERDAY	ON A TYPICAL DAY
	<i>Whole grains</i>		
	<i>Vegetables and legumes</i>		
	<i>Fruit</i>		
	<i>Milk, yoghurt, cheese and/or alternatives</i>		
	<i>Lean meats, poultry, fish, eggs, tofu, nuts, and seeds</i>		
	<i>Cakes, chips, lollies, pizza, burgers etc.</i>		
	<i>Glasses of water (250ml)</i>		
	<i>Standard drinks of alcohol</i>		
	<i>Cups of coffee</i>		
	<i>Cups of tea</i>		
	<i>Soft drinks (250 ml)</i>		
	<i>Energy drinks</i>		

What is your height? _____ cm

What is your weight? _____ kg

What is your waist circumference? _____ cm

Physical Activity

The following questions ask about **HOW MANY MINUTES** you spent doing different types of physical activities **each day**, over the **PAST WEEK**. Start with yesterday and then work your way back seven days.

	Minutes each day over the past week							Was this a typical week?
	Yesterday	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	
Moderate intensity physical activity								YES/NO
Vigorous intensity physical activity								YES/NO
Muscle strengthening activity								YES/NO

Definitions

Moderate intensity activity - Moderate intensity physical activity requires some effort, but still allows you to speak easily while undertaking the activity. Examples include active play, brisk walking, recreational swimming, dancing, social tennis, or riding a bike or scooter.

Vigorous intensity physical activity requires more effort and makes you breathe harder and faster (“huff and puff”). Examples include running, fast cycling, many organised sports or tasks that involve lifting, carrying or digging.

Over the **PAST FOUR WEEKS**, have you had any of the following problems?

Problem	No	Yes
Constant thirst		
Change in urine colour or frequency		
Bedwetting		
Diabetes		
Problems with vision		
Multiple bacterial infections		
Indigestion		
Nausea		
Diarrhoea		
Constipation		
Bruising		
Seizures		
Fatigue		
Joint swelling		
Skin rashes		
Muscle weakness		
Frequent headaches		
Daytime tiredness		
Memory problems		
Changes in appetite		
Unintended weight loss or gain		
Change in sexual interest		
Dry eyes or mouth		
Dry or itchy skin		
Dry, brittle hair or nails		
Chronic cough		
Sensitivity to light		
Sensitivity to sound		
Cold intolerance		
Heat intolerance		
Acne		
Eczema		
Sinus inflammation		
Abdominal pain		
Back pain		
Chest pain		
Other pain		
Chest palpitations		
Numbness in hand or other part of body		
WOMEN ONLY		
Menstrual irregularities		
Premature menopause		

In the table below, list your current illnesses and/or psychological disorders, treatment providers and current treatments you are receiving, including medications you are taking.

CONDITION	TREATING DOCTOR	TREATMENT