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PRIVATE AND CONFIDENTIAL Number …….

FULL HEALTH SCREENING QUESTIONNAIRE

Surname …… Forename(s) ……

Title Mr/Mrs/Miss/Ms/Dr/Other ……DoB ……..…….

Home Address ……..

…… Tel. No ……

Company Address (if applicable) ……

…… Tel. No. ……...

Name of General Practitioner ……..…..

Address of General Practitioner ……...

……..... Tel. No. (if known) ……

Please indicate with a tick your reason for attending:

PERSONAL REASSURANCE □ A PARTICULAR PROBLEM □

COMPANY SCHEME □ OTHER REASON □

INTRODUCTION

The purpose of this questionnaire is to provide the Doctor with information regarding your state of health in preparation for the Health Screening Examination.

Your co-operation will allow the Doctor to produce the most accurate health assessment. Therefore, please answer the following questions to the best of your ability.

Should you feel unable to answer any particular question(s), do not be concerned - these may be discussed with the Doctor, if you desire.

FAMILY HISTORY

	AGE	STATE OF HEALTH (if not good, give details)	AGE AT DEATH AND CAUSE (if known)
MOTHER			
FATHER			
BROTHERS			
SISTERS			
SPOUSE			
CHILDREN			

Please indicate with a tick, and give details, if any of your blood relatives have suffered from any of the following illnesses. Please indicate their relationship to yourself, where applicable.

High Blood Pressure ……. Heart Trouble ……..……..

Stroke ……..... Tuberculosis ……....……

Asthma …….. Other Chest Problems ……...

Diabetes …… Thyroid Problems ……..

Gout …….. Stomach Ulcer ……...

Epilepsy (fits) …… Alcoholism …….

Mental Illnesses …… Paralysis ……

Eye Problems …… Kidney Problems ……...

Blood Disorders …… Joint Problems ……...

Skin Disorders …….. Cancer ……

Any other diseases which “run in the family” ……....

……

PAST MEDICAL HISTORY

Please answer all questions in this section and give details, where possible.
Have you had any of the following:

(a) Serious childhood illnesses ……....

……

……

(b) Operations

Date	Nature of Operation	Hospital	Any lasting side effects

(c) Serious accidents or injuries (please give dates and nature)

	Date	Nature
1		
2		
3		
4		

(d) Any significant illnesses in adult life

	Date	Nature
1		
2		
3		
4		

(e) A chest X-Ray (if so, what was the result) ……...

THIS NEXT 3 PAGE SECTION

FOR FEMALE HEALTH SCREEN ONLY

(f) Gynaecological History

Details of Operations/Illnesses	Age	Duration

(g) Obstetric History

Pregnancy (year)	Duration of Pregnancy	Ante-Natal Problems	Labour Difficulties

Problems of Delivery	Health of Baby	Birth Weight

Have you had any miscarriages? Yes ☐ No ☐

If yes, please give details ……..

……

MENSTRUAL HISTORY

(a) Do you have periods? Yes ☐ No ☐

Age at which periods started ……..

(b) If yes, are your periods regular? Yes ☐ No ☐

How many days in your cycle? ……

How many days do you normally bleed for? ……

Are your periods heavy? Yes ☐ No ☐

Do you have bleeding between periods? Yes ☐ No ☐

Do you pass clots? Yes ☐ No ☐

If your periods are heavy, please indicate severity:

Minimal ☐ **Moderate** ☐ **Severe** ☐

Do you lose blood after intercourse? Yes ☐ No ☐

(c) If no, date of last menstrual period ..……

How long ago did your periods stop? ……

Have you had any vaginal bleeding since then? Yes ☐ No ☐

Do you have hot flushes/night-time sweating? Yes ☐ No ☐

If yes, please give details ……..

……....

Any other problems not mentioned? If so, please give details ……

……

(d) Are you troubled with vaginal discharge? Yes ☐ No ☐

If yes, please give details ……...

……

(e) Do you feel you suffer from pre-menstrual symptoms/syndromes? Yes ☐ No ☐

If yes, please give details ……...

……

Have you consulted a doctor about this? Yes ☐ No ☐

CONTRACEPTION

(a) Do you use any type of contraception? Yes ☐ No ☐

If yes, please give details below:

Contraceptive pill ……..

Minipill ……

"Coil" …… Sheath ……..….

Partner has had a vasectomy ……. Other method (give details) ……

CERVICAL

(a) Give approximate date of your last cervical smear ……..

(b) Was this the only smear you have had? Yes □ No □

(c) How often do you have a smear? ……

(d) Has any smear shown an abnormality? Yes □ No □

If yes, please give details……

(e) Have you been vaccinated against German Measles? Yes □ No □

If yes, have you had a blood test to show that you are Yes □ No □
Immune (protected against German Measles)?

SEXUAL DIFFICULTIES

(a) Do you have any sexual difficulties? Yes □ No □

(b) Do you suffer from pain during intercourse Yes □ No □

(This can be discussed in strictest confidence with me, if so desired)

BREAST

(a) Do you regularly examine your breasts? Yes □ No □

(b) Have you ever found a lump in either breast? Yes □ No □

If yes, please give details ……

……

……

(c) Did you breast feed any of your children? Yes □ No □

If yes, approximately for how long? …….....

(d) Is there a family history (blood relatives) of breast cancer? Yes □ No □

If yes, please give details ……..

……...…

PRESENT HEALTH

The following questions enquire into your present state of health (during the last year).
Are you troubled with any of the following?

(a) Shortness of breath	Yes ☐	No ☐
(b) Regular cough	Yes ☐	No ☐
If yes, is the cough productive of sputum?	Yes ☐	No ☐
(c) Coughing up of blood	Yes ☐	No ☐
(d) Wheezing in your chest	Yes ☐	No ☐
(e) Chest pain	Yes ☐	No ☐
(f) Swollen ankles	Yes ☐	No ☐
(g) The sensation of your heart beating fast or irregular	Yes ☐	No ☐
(h) Cramp or pain in your legs when walking	Yes ☐	No ☐
(i) Cramp in your legs at night	Yes ☐	No ☐
(j) Varicose veins	Yes ☐	No ☐

GASTRO-INTESTINAL

(a) A recent change in your appetite	Yes ☐	No ☐
(b) Changes in weight, by at least 7lbs (3Kgs) in last year	Yes ☐	No ☐
(c) Pains in abdomen	Yes ☐	No ☐
(d) Nausea or vomiting	Yes ☐	No ☐
(e) Difficulty or pain on swallowing food or drink	Yes ☐	No ☐
(f) Indigestion, heartburn or “wind” regularly	Yes ☐	No ☐
(g) Diarrhoea, constipation or a variable bowel habit	Yes ☐	No ☐
(h) Blood in your motions	Yes ☐	No ☐
(i) Piles (haemorrhoids)	Yes ☐	No ☐
(j) Irritation around the back passage	Yes ☐	No ☐

URO-GENITAL

(a) Difficulty in passing urine	Yes ☐	No ☐
(b) Blood in urine	Yes ☐	No ☐
(c) Passing urine more frequently than last year	Yes ☐	No ☐
(d) A problem with your sex organs	Yes ☐	No ☐
(e) Cystitis or discomfort when passing urine	Yes ☐	No ☐
If yes, does it happen often?	Yes ☐	No ☐
Have you consulted a doctor?	Yes ☐	No ☐
(f) Do you ever “wet yourself” when laughing or crying?	Yes ☐	No ☐

Do you ever “wet yourself” for no specific reason? Yes ☐ No ☐

(g) Can you “hold your urine”? Yes ☐ No ☐

NERVOUS SYSTEM and OPHTHALMIC

(a) Do you wear contact lenses Yes ☐ No ☐

ARE YOU TROUBLED BY:

(a) Frequent or regular headaches Yes ☐ No ☐

(b) Difficulty with your eyesight (blurring or double vision) Yes ☐ No ☐

(c) Blackouts, dizzy spells or faints Yes ☐ No ☐

(d) Weakness, numbness or tingling Yes ☐ No ☐

EAR, NOSE and THROAT

Have you noticed:

(a) Any difficulty with your hearing Yes ☐ No ☐

(b) Your voice has become permanently hoarse Yes ☐ No ☐

(c) Any problems with your ears Yes ☐ No ☐

(d) Any problems with your nose or sinuses Yes ☐ No ☐

(e) A persistent sore throat or other throat trouble Yes ☐ No ☐

(f) Any dental problems Yes ☐ No ☐

LOCOMOTOR and SKIN

Have you noticed:

(a) Stiff or painful joints Yes ☐ No ☐

(b) Frequent or persistent back pain Yes ☐ No ☐

(c) Lumps, swellings or other skin problems Yes ☐ No ☐

PSYCHOLOGICAL

(a) Have you had any difficulty sleeping recently Yes ☐ No ☐

(b) Suffered from persistent depression of mood Yes ☐ No ☐

(c) Noticed any problem with your memory Yes ☐ No ☐

(d) Been troubled with odd thoughts or ideas Yes ☐ No ☐

(e) Been more anxious recently Yes ☐ No ☐

(f) Have you had any particular worries recently Yes ☐ No ☐

Do you have any symptoms or problems which have not been mentioned so far? Yes ☐ No ☐

If yes, please give details:

……

……

ALLERGIES and MEDICATIONS Please bring all medicines with you.

(a) Please list any medicines or tablets to which you are sensitive or allergic:

……..…

(b) Apart from the medicines above, do you suffer from any other allergies e.g. to grass/pollen?
If yes, please give details:

……

(c) Please list all medications or tablets you are currently prescribed by your doctor:

	MEDICATION	REASON FOR TAKING
1		
2		
3		
4		
6		
7		

(d) Do you take any medicines other than prescribed by a Doctor ("over-the-counter medications" such as laxatives, indigestion tablets etc)?

……..…….

……

……..……

(e) Have you completed a tetanus course? Yes □ No □

(f) Have you had a tetanus booster in the last ten years? Yes □ No □

PERSONAL HISTORY

Marital Status

(a) Single/Married/Divorced/Separated/Widowed

(b) Length of present marriage ……..

(c) Have you been married before? Yes ☐ No ☐

If yes, date of marriage …… Outcome of marriage ……..…

(d) What is your spouse's occupation? ……

(e) Are there any problems in your present marriage? Yes ☐ No ☐

OCCUPATIONAL HISTORY

(a) What is your present occupation? ……

(b) Please outline briefly what it involves ……

……

……

(c) Length of present occupation …… years

(d) Please outline any training you have undergone ……

……

(e) Give brief details of previous occupation/s ……..……

……..…

(f) Do you enjoy your present job? Yes ☐ No ☐

(g) Do you feel that the pressures of the job affect your health in any way? Yes ☐ No ☐

(h) How many hours a week do you spend working? …….. hours

(i) Do you have any serious financial worries? Yes ☐ No ☐

(j) How many miles do you travel yearly with your job? …… miles

(k) Do you travel abroad with your job? Yes ☐ No ☐

(l) Have you visited tropical or a sub-tropical country during the last twelve months? Yes ☐ No ☐

If yes, where? ……

ALCOHOL and SMOKING HISTORY

(a) Do you smoke? Yes ☐ No ☐

If yes, for how many years? …….

(b) Cigarettes – number per day ……. Cigars – number per day ……

Pipe tobacco – ounces per week …….

(c) Did you smoke? Yes ☐ No ☐

If yes, when did you stop smoking? ……..

(d) Have you ever tried to give up smoking? Yes ☐ No ☐

(e) Do you drink alcohol? Yes ☐ No ☐

(f) If yes, please indicate relevant quantities:

Wine – glasses per week …….. Spirits – singles per week …….

Beer – pints per week ……. Other ……..

(g) Do you drink alcohol every day? Yes ☐ No ☐

(h) Has your drinking ever caused a serious problem e.g. driving, with work or relationships Yes ☐ No ☐

(i) Have you ever felt your drinking to be excessive? Yes ☐ No ☐

EXERCISE/LEISURE HISTORY

(a) Do you regularly take part in any type of physical activity or exercise? Yes ☐ No ☐

If yes, briefly describe this ……..……

……..……..

……..……

(b) Please describe any hobbies or interests, other than work or sport, that you may have:

……..…

……..……

(c) Do you have any pets? Yes ☐ No ☐

If yes, please give details ……..……

ANY ADDITIONAL COMMENTS YOU WISH TO MAKE:

Do you wish your name to be placed on our Recall Register for repeat health screening? Yes ☐ No ☐

If yes, how often would you like to be recalled?

ANNUALLY	EVERY 2 YEARS	EVERY 3 YEARS

END OF QUESTIONNAIRE

Signature …… Date …….