MEDICIS
Health Testing Center
Avenue de Tervueren 236
1150 Bruxelles
Tel : 02/762.50.44

Medical Questionnaire

Name : ……..…

Maiden name : ……

First name : ……..… Sex : ……..……

Address : ……...……...

Phone (private) : …… Office : …….

Date of birth : …… Nationality : ……..…..

Employer : …… Profession : ……

General practitioner : ……..……

The purpose of this questionnaire is to obtain an insight into your state of health and to provide the doctor with information about it.

Please complete this questionnaire carefully at home and bring it with you the day of your medical screening..

If your answer is « YES », please check « YES » and give any information which you might consider useful in the column marked « details ».

If your answer is « NO », leave the space blank.

FAMILY HISTORY

Did or does a member of your family suffer from any of the following conditions ?

			YES	DETAILS
F	01	Sudden death	0	
	02	Heart attack	0	
	03	Cerebrovascular accident (stroke)	0	
	04	High bloodpressure	0	
	05	Angina pectoris	0	
	06	Artritis	0	
	07	Diabetes	0	
	08	Gout (uric acid)	0	
	09	Bowel cancer	0	
	10	Stomach cancer	0	
	11	Lung cancer	0	
	12	Breast cancer	0	
	13	Gynaecological cancer	0	
	14	Gallstones	0	
	15	Kidney stones	0	
	16	Asthma	0	

PERSONAL ANTECEDENTS

			YES	DETAILS
Have you been treated or hospitalised for:				
P	01	Lungs	0	
	02	Heart	0	
	03	Blood vessels	0	
	04	Nervous system	0	
	05	Stomach or bowels	0	
	06	Kidney and urinary tract	0	
	07	Liver	0	
	08	Gyn. problems	0	
	09	Endocrine glands	0	
	10	Infection	0	
	11	Bone or joints	0	
	12	Congenital problems	0	
	13	Lumps	0	
	14	Other	0	

P		YES	DETAILS
15	Were there problems during your pregnancies?	0	
16	Have you ever had more than two weeks sickleave ?	0	
17	Did you have any surgery ?	0	
18	Did you ever have chemotherapy, radiotherapy, or have you ever been treated with hormones ?	0	
19	Were you ever victim of an accident ?	0	
20	Have you ever had a blood transfusion ?	0	
21	Has an anomaly been found in a previous screening ?	0	
22	Have you spent any time in tropical countries ?	0	
23	Are you allergic to any substance ?	0	

WAY OF LIVING - HABITS

		YES	DETAILS
01	Do you consider yourself in bad health ?	0	
02	Are you married ?	0	
03	Are you divorced ?	0	
04	Do you have children ?	0	
05	Do you sleep well ?	0	
06	Do you smoke ?	0	
07	Do you regularly drink alcohol ?	0	
08	Do you drink more than 5 cups of coffee a day ?	0	
09	Do you eat a lot of sweets ?	0	
10	Do you eat a lot of meat, eggs, cheese or butter ?	0	
11	Are you on a diet ?	0	
12	Do you wish dietary advice ?	0	

		YES	DETAILS
13	Do you take any medication	0	
	- sleeping pills ?	0	
	- transquilizers ?	0	
	- antidepressives ?	0	
	- antihypertensives ?	0	
	- heart pills	0	
14	Do you take any drugs ?	0	
15	Are you working full time ?	0	
16	Do you have a hobby ?	0	
17	Do you have social activities ?	0	

GENERAL QUESTIONS

		YES	DETAILS
18	Are you feeling tired ?	0	
19	Have you lost or gained weight ?	0	
20	Have you lost your appetite ?	0	
21	Do you sometimes have an unexplained temperature ?	0	
22	Do you have unexplained pains ?	0	
23	Are you sweating abnormally ?	0	

CARDIOVASCULAR AND PULMONARY SYSTEM

		YES	DETAILS
24	Are you short of breath	0	
	- at rest ?	0	
	- during exercice ?	0	
	- during the night ?	0	
	- after the meals ?	0	
25	Do you feel a tightness of the chest ?	0	
26	Do you have palpitations ?	0	
27	Do you regularly suffer from swollen feet ?	0	
28	Do your legs hurt while walking ?	0	

		YES	DETAILS
29	Do you suffer of a feeling of heaviness in the legs ?	0	
30	Do you have varicose veins ?	0	
31	Are the fingers easily white, blue or painful ?	0	
32	Do you often cough ?	0	
33	Do you frequently have phlegm ? With blood, green ?	0	
34	Do you often have bronchitis ?	0	
35	Are you wheezing ?	0	
36	Do you have asthma ?	0	

GASTRO INTESTINAL SYSTEM

		YES	DETAILS
37	Do you regularly have abdominal pain ?	0	
38	Do you have nausea, are you often vomiting ?	0	
39	Do you have irregular stool ? With blood, black ?	0	
40	Are you intolerant towards certain foods ?	0	
41	Do you have digestive problems ?	0	
42	Do you have hemorrhoïds ?	0	

URO – GENITAL SYSTEM

		YES	DETAILS
43	Do you have problems with urinating?	0	
44	Do you have to urinate during the night ?	0	
45	Do you have to urinate more frequently recently ?	0	
46	Do you have bloody urine ?	0	
47	Are the testicles painfull or swollen ?	0	
48	Do you have a problem with the penis	0	

GYNAECOLOGICAL SYSTEM

		YES	DETAILS
49	Are you completed menopause ?	0	
50	Are the menses irregular ?	0	
51	Do you lose blood between the menses ?	0	
52	Are the breasts swollen before the periods ?	0	
53	Have you noticed a outflow of the breasts ?	0	
54	Have you noticed any nodule in the breasts ?	0	
55	Have you abnormal vaginal discharge ?	0	
56	Are the sexual intercourses painful ?	0	
57	Do you have any vulvar problems (itching, ulcers, …)	0	
58	Do you use any contraceptive ?	0	

NEUROLOGICAL SYSTEM

		YES	DETAILS
59	Do you have dizziness ?	0	
	Do you have syncopes ?	0	
60	Do you have pricking sensations in arms and legs ?	0	
61	Have you noticed a loss of sensibility ?	0	
62	Have you noticed a loss of muscular strength ?	0	
63	Do you have tremors?	0	
64	Do you have problems with the		
	- balance ?	0	
	- speech ?	0	
	- memory ?	0	
65	Did or do you have convulsions ?	0	
66	Do you regularly have headaches ?	0	
67	Have you noticed any changes in your personality ?	0	

E.N.T.

		YES	DETAILS
68	Are there any hearing problems in your family ?	0	
69	Do you have problems with the ears ? (ringing in the ears)	0	
70	Have you noticed a loss of hearing ?	0	
71	Do you bleed from the nose ?	0	
72	Do you have a chronic nasal or postnasal drip ?	0	
73	Do you have problems with the mouth, tongue or throat ?	0	
74	Have you noticed a hoarseness lately ?	0	
75	Do you have problems swallowing ?	0	

BONE AND JOINTS

		YES	DETAILS
76	Do you have morning stiffness in the joints ?	0	
77	Do you have joint pain while exercising ?	0	
78	Do you have back pains ?	0	
79	Do you easily have bone fractures ?	0	
80	Do you have a history of muscular,joint or ligament problems?	0	
81	Do you have neckpains ?	0	
82	Do you have muscular cramps during exercise ?	0	
83	Do you have pain in arms or legs ?	0	

EYES AND SKIN

		YES	DETAILS
84	Do you have a skin problem ?	0	
85	Has a beauty mark or mole changed recently (growing, itching, bleeding, …)	0	

86	Do you lose your hair ?	0	
87	Do you easily have skin rashes, itching, acne ?	0	

		YES	DETAILS
88	Do you feel some tension or pain in the eyes ?	0	
89	Are the eyes itchy, prickly …	0	
90	Has your vision changed lately ?	0	
91	Is your color vision normal ?	0	
92	Do you have a vision problem ? Are you wearing glasses?	0	

BLOOD, IMMUNITY AND ENDOCRINE GLANDS

		YES	DETAILS
93	Are you bleeding easily ?	0	
94	Do you easily have bruises ?	0	
95	Have you noticed the presence of swollen lymph glands ?	0	
96	Do you frequently have infections ?	0	
97	Do these infections cure easily?	0	
98	Do you sneeze easily ?	0	
99	Do you have hay fever?	0	
100	Do you have any allergy towards : - drugs ? - food ? - others ?	0 0 0 0	