ASBL - VZW
medicis
HEALTH TESTING CENTRE

MEDICAL QUESTIONNAIRE

To be completed only during your first visit.

The principle of preventive medicine is to attempt to detect health problems early.

Follow-ups, potential additional tests, final diagnosis, and treatment will be carried out by your GP. It is therefore essential to forward a copy of the file you will receive following the examination to your GP.

Please note that no prescriptions for medication or treatment can be requested in preventive medicine.

Name :
Maiden Name :
First Names :
Gender :
Address :
Home Phone Number :
Work Phone Number :
Email Address :
Date of Birth :
Nationality :
Employer :
Profession :
GP (nom et adresse) :

FAMILY HISTORY

When completing the table below, consider the following

Cardiovascular:

- Myocardial infarction / heart attack / sudden death
- Stents or bypass
- Angina
- Arteritis (arterial disease)
- Stroke (CVA, "attack" or thrombosis)
- Hypertension
- Familial hypercholesterolemia

Diabetes:

- Type 1 diabetes (occurs at a young age, requires insulin injections)
- Type 2 diabetes (develops later, treated with oral medication)

Cancer :

- Breast – Uterus/Ovaries - Prostate – Intestines/Colon – Lungs – Stomach – Melanoma/Skin - Other

Glaucoma

Degree of Relation	Illness	Age of Onset
Father		
Mother		
Brother 1		
Brother 2		
Sister 1		
Sister 2		
Maternal Family: Grandfather Grandmother Uncle(s)/Aunt(s)		
Paternal Family: Grandfather Grandmother Uncle(s)/Aunt(s)		

PERSONAL MEDICAL HISTORY

Have you suffered from / or been hospitalised for any condition?	*If yes, tick*	*Year?*	*Details*
Hypercholesterolemia	☐		
Hypertension	☐		
Diabetes	☐		
Cardiac (heart attack, stent, bypass, arrhythmia, valve problem…)	☐		
Vascular (stroke, TIA, arteritis, varicose veins…)	☐		
Pulmonary (asthma, chronic bronchitis, sleep apnoea, polysomnography…)	☐		
Endocrine (diabetes, thyroid…)	☐		
Gastro-intestinal/digestive (stomach, pancreas, peritonitis, intestines, diverticulitis…)	☐		
Hepatic (liver, gallbladder…)	☐		
Kidney	☐		
Urinary (prostate, bladder, kidney stones…)	☐		
Osteoarticular and rheumatologic (fractures, ligament, muscular or joint injuries)	☐		
Neurological (migraine, epilepsy…)	☐		
Ophthalmological (glaucoma, cataract, macula…)	☐		
ENT (ear, nose, throat)	☐		
Haematological/blood disorders (anaemia, iron issues, leukaemia, lymphoma…)	☐		
Coagulation (embolism, thrombosis, phlebitis, haemophilia…)	☐		
Infectious or tropical diseases	☐		
Psychological (burnout, depression, anxiety…)	☐		
Dermatological/skin disorders	☐		
Cancer treatment (chemotherapy, radiotherapy, hormones…)	☐		
Consequences of an injury	☐		
Other :	☐		

PERSONAL SURGICAL HISTORY

Have you had surgery for any condition?	If yes, tick	Year?	Details
Pulmonary	☐		
ENT (ear, nose, throat)	☐		
Cardiovascular (heart, arteries, veins…)	☐		
Neurological	☐		
Gastro-intestinal (appendix, liver, gallbladder, polyps…)	☐		
Renal or urinary (prostate, bladder…)	☐		
Endocrine (thyroid)	☐		
Orthopaedic or traumatic	☐		
Ophthalmological (refractive surgery, cataract, glaucoma…)	☐		
Dental (wisdom teeth, jaw…)	☐		
Congenital malformations	☐		
Other :	☐		

GYNAECOLOGICAL HISTORY

Questions	Answers
Age of first menstruation?	
Number of pregnancies (including miscarriages and terminations)?	
Illness during pregnancy (hypertension, eclampsia, diabetes…)?	
Years of deliveries?	
Breastfeeding for over 3 months?	
Do you use contraception? Pill – Vaginal ring – Implant – Non-hormonal coil – Hormonal coil – Tubal ligation – Condom – Other	
Are your periods painful - heavy - irregular?	
Date of last period?	
Age at menopause?	
Have you taken hormone replacement therapy? For how long?	
Have you suffered from / been hospitalised for / had surgery for any gynaecological or breast condition?	

SCREENING TESTS

Which screening tests have you undergone?	*If yes, tick*	*Year?*	*Results*
Colon Cancer (aged 45+): • Colonoscopy? • Blood stool test using colotest (iFobt - hemoccult)?	☐ ☐		
Skin Cancer: • Skin screening by a dermatologist?	☐		
Cardiovascular Prevention (aged 45+): • Cardiac check-up? • Stress test?	☐ ☐		
Lung Cancer (smokers and ex-smokers aged 50+): • Pulmonary function test by a pulmonologist? • Lung scan?	☐ ☐		
Glaucoma (40 ans+) : • Eye pressure test by an ophthalmologist?	☐		
Dental Check-up?	☐		
For Women:			
Cervical Cancer: • Gynaecological smear test? • HPV test?	☐ ☐		
Breast Cancer (aged 40+): • Mammogram? • Breast palpation?	☐ ☐		
Osteoporosis (post-menopause): • Bone density scan?	☐		
For Men:			
Prostate Cancer (aged 50+): • PSA test? • Urological exam? (with ultrasound or MRI)	☐ ☐		

ALLERGIES - INTOLERANCES

Are you prone to any of the following allergies/intolerances?	*If yes, tick*
Intolerance :	☐
• Lactose	☐
• Gluten	☐
• Have you undergone a test to confirm this intolerance?	☐
Allergy :	☐
• Medication	☐
• Food	☐
• Respiratory / Allergic Rhinitis ("hay fever")	☐
• Skin (insect bites, eczema, hives)	☐
• Quincke's oedema / Anaphylactic shock	☐
• Have you undergone skin or blood allergy tests?	☐

MEDICATIONS AND TREATMENTS

What medications do you take <u>regularly</u>?

Name	Dose (mg)	Number of doses per day	Since when ?

What medications do you take <u>occasionally</u>?

Name	Dose (mg)	Number of doses per day	Since when ?

Specifically consider:

- Sleeping pills – Tranquilisers – Antidepressants?
- Antihypertensives – Anticoagulants – Heart medications – Cholesterol – Diabetes?
- Contraception? Menopause treatment?
- Eye drops?
- Creams?

Other types of treatments:	*If yes, tick*
CPAP or sleep apnoea treatment	☐
Hearing aids	☐
Compression stockings – Orthopaedic insoles	☐
Physiotherapy – Osteopathy	☐
Psychotherapy	☐
Pacemaker	☐

VACCINATIONS

Please bring your vaccination card if possible

Type	*Date of last dose*	*Total doses*
Tetanus, Diphtheria, Pertussis (1x/10 years)		
Poliomyelitis		
Influenza (aged 65+)		
Pneumococcus (aged 65+)		
COVID (aged 65+)		
Shingles (aged 65+)		
Hepatitis A		
Hepatitis B		
Yellow Fever		
Measles, Rubella, Mumps		
HPV		
Other: Meningitis ACWY, Typhoid fever, Rabies, FSME, Tick-borne Encephalitis		

LIFESTYLE HABITS

Questions	*If yes, tick*	*Details / Answers*
Smoking :		
• You have never smoked	☐	
• You stopped smoking in …. (year) ○ You smoked for … years ○ How many per day?	☐	
• Do you currently smoke: ○ Cigarettes – Cigars/Cigarillos – Pipe – Rolling tobacco – Cannabis – E-cigarettes/vaping ○ How many per day? ○ For how many years? ○ Have you ever quit smoking? ○ Do you intend to quit smoking? ○ When do you smoke your first cigarette after waking up? ▪ 5 min – 30 min – 60 min - >60 min	☐	
Do you consume drugs or narcotics?	☐	
Physical Activities:		
• How many times a week do you engage in at least: ○ 30 minutes of moderate physical activity (walking, cycling, dancing, yoga, gardening)? ○ 25 minutes of intense physical activity (fitness, running, tennis, football, intense cycling)? • Which activities?		
Diet :		
• Do you follow a specific diet? ○ Lactose-free / Gluten-free ○ Low salt / sugar / cholesterol ○ Vegetarian / Vegan	☐	
• Do you have a daily source of calcium? ○ Dairy products ○ Legumes ○ Green vegetables ○ Almonds and nuts ○ Calcium-rich water (e.g., Hepar, Contrex, San Pellegrino)	☐	
• How many portions of 100g of fruits and/or vegetables do you consume **per day**? (100g = approx. one apple or carrot)		

LIFESTYLE HABITS - CONTINUED

Questions	*If yes, tick*	*Details / Answers*
Diet – Continued :		
• How often per week do you consume: ○ Red meat or equivalent (minced, pork, charcuterie…)? ○ White meat – Poultry? ○ Fish – Shellfish – Seafood? ○ Eggs? ○ Plant-based proteins (legumes, tofu, quinoa…)? ○ Whole grains – Seeds		
• What is your daily fluid intake (in litres)? ○ Water ○ Sodas and juices ○ Coffee – Tea – Coca-Cola – Energy drinks ○ Other (soups, milk…)?		
• Alcoholic beverages (1 unit = 25cl beer, 10cl wine, 2.5cl spirit at 40°): ○ Do you consume more than 10 units per week? ○ Do you observe at least 2 alcohol-free days per week? ○ How often do you drink more than 2 units per day?	☐ ☐	

https://healthwell.eani.org.uk/healthtopic/alcohol-guidance/how-much-am-i-drinking

CURRENT HEALTH PROBLEMS

SLEEP

Questions	*If yes, tick*	*Details*
Do you suffer from sleep disorders? • Difficulty falling asleep • Difficulty staying asleep (frequent nocturnal awakenings, early waking)	☐ ☐	

Epworth Sleepiness Scale

What is the likelihood of dozing off in the following 8 situations?

Situation	0 – No chance	1 – Slight chance	2 – Moderate chance	3 – High chance
1. Sitting and reading	○	○	○	○
2. Watching TV	○	○	○	○
3. Sitting in a car for an hour without a break	○	○	○	○
4. As a passenger in a vehicle in traffic or for an hour without stopping	○	○	○	○
5. Sitting quietly after lunch without alcohol	○	○	○	○
6. Talking to someone	○	○	○	○
7. In a meeting or conference	○	○	○	○
8. Sitting in a quiet place after an activity	○	○	○	○
			Score	

CARDIOCIRCULATORY AND RESPIRATORY SYSTEM

Questions	If yes, tick	Details
Tightness or pain in the chest (at rest – during exertion – under stress)?	☐	
Shortness of breath (at rest or during exertion)?	☐	
Palpitations?	☐	
Cough?	☐	
Phlegm? Colour?	☐	
Hoarseness or voice roughness?	☐	
Pain in the legs while walking? After how far?	☐	

DIGESTIVE SYSTEM

Questions	If yes, tick	Details
Change in bowel movement frequency?	☐	
Diarrhoea?	☐	
Constipation?	☐	
Acid reflux ("heartburn")? How often?	☐	
Blood in stools or after passing stools?	☐	
Recent weight change? How many kg and over how long?	☐	

UROGENITAL SYSTEM

Have you noticed:	*If yes, tick*	*Details*
• Blood in urine? • Urine leakage during exertion – coughing – laughing? • How many times per night do you wake to urinate?	☐ ☐ ☐	

For Men:

IPSS : International Prostate Score Symptom						
In the past month, how often have you experienced:	**Never**	**1 out of 5 times**	**1 out of 3 times**	**1 out of 2 times**	**2 out of 3 times**	**Almost Always**
Feeling that your bladder was not completely emptied after urinating?	0	1	2	3	4	5
Needing to urinate again less than 2 hours after finishing?	0	1	2	3	4	5
Interruption of urine stream?	0	1	2	3	4	5
Difficulty holding urine after feeling the urge?	0	1	2	3	4	5
Weak urine stream?	0	1	2	3	4	5
Pushing or straining to start urination?	0	1	2	3	4	5
	Never	**1 time**	**2 times**	**3 times**	**4 times**	**5 times**
How many times did you need to wake up at night to urinate?	0	1	2	3	4	5
					TOTAL IPSS :	

- 0 – 7 = Mild
- 8 – 19 = Moderate
- 20 – 35 = Severe

Quality of Life Assessment Related to Urinary Symptoms:							
Circle the answer that applies to you	**Very satisfied**	**Satisfied**	**Somewhat satisfied**	**Neutral**	**Somewhat unhappy**	**Unhappy**	**Very unhappy**
If you had to live the rest of your life with this urinary pattern, would you say you would be:	0	1	2	3	4	5	6

NEUROLOGICAL SYSTEM

Questions	If yes, tick	Details
Do you experience unexplained loss of consciousness?	☐	
Do you experience headaches? • Frequency (per day – week – month)? • Recent occurrence or chronic issue?	☐ ☐	

MUSCULOSKELETAL SYSTEM

Questions	If yes, tick	Details
Do you experience back pain? Upper – Middle – Lower back?	☐	
Other joint pain?	☐	
Swollen joints? Which ones?	☐	
Have you undergone examinations for these pains (X-ray, scan, MRI, ultrasound)?	☐	

ENT (Ear, Nose, and Throat)

Questions	If yes, tick	Details
Do you experience tinnitus? • How long? • Have you undergone evaluation for tinnitus?	☐	
Have you noticed hearing problems?	☐	

DERMATOLOGY

Questions	If yes, tick	Details
Are you regularly monitored by a dermatologist? How often?	☐	
Experiencing skin problems?	☐	
Noticing a birthmark or mole that has appeared or recently changed?	☐	
Prone to rashes or itching?	☐	

OPHTHALMOLOGY

Questions	If yes, tick	Details
Are you suffering from • Myopia (problem seeing far away) • Hyperopia (problem seeing up close) • Presbyopia (problem seeing up close after age 40)	☐ ☐ ☐	
Do you have an eye disease?	☐	
Do you have known and/or treated intraocular hypertension or glaucoma?	☐	

HEMATO IMMUNE SYSTEM

Questions	If yes, tick	Details
Have you ever had an iron deficiency or anemia?	☐	
Do you have a coagulation problem?	☐	

PROFESSIONAL AND/OR PRIVATE STRESS

Questions	If yes, tick	Details
Source of stress: • Work-related due to workload • Work-related due to relationships with colleagues • Personal	☐ ☐ ☐	
Do you feel that your current stress level is under control?	☐	
Do you feel that your stress affects: • Your sleep • Your concentration/memory • Mood/anxiety/irritability • Your energy for activities after work	☐ ☐ ☐ ☐	
Are you receiving psychological support?	☐	

Please complete the following questionnaire:

Perceived Stress Scale (PSS 10)

This test is the most commonly used and simplest tool to assess an individual's perception of stress. The result is not a medical diagnosis. It gathers information about the potential need to adjust aspects of your personal or professional life and, if necessary, seek medical or psychotherapeutic help.

The test won't take much of your time. Answer quickly and as spontaneously as possible. The questions relate to your feelings over the past month.

Check the box that best reflects how you have felt over the past month:	*Never*	*Rarely*	*Sometimes*	*Fairly Often*	*Very Often*
1. Have you been upset by an unexpected event?	○	○	○	○	○
2. Did you feel it was difficult to control the important things in your life?	○	○	○	○	○
3. Have you felt nervous and stressed?	○	○	○	○	○
4. Did you feel confident in your ability to handle your personal problems?	○	○	○	○	○
5. Did you feel that things were going the way you wanted?	○	○	○	○	○
6. Did you feel that you could not cope with all the things you had to do?	○	○	○	○	○
7. Were you able to control your irritation?	○	○	○	○	○
8. Did you feel that you were on top of things?	○	○	○	○	○
9. Have you felt irritated because events were out of your control?	○	○	○	○	○
10. Did you feel that difficulties piled up to the point that you could not overcome them?	○	○	○	○	○