ASBL - VZW
medicis
HEALTH TESTING CENTRE

MEDICAL QUESTIONNAIRE

You are going to undergo a preventive medicine exam.

The purpose of this questionnaire is to produce an overview of your state of health and to provide the doctor with information related to this.

The principle of preventive medicine is to detect health problems; note that the responsibility for handling them and treating them belongs to your General Practitioner (G.P.). That is why we recommend that you provide him/her with a copy of the record that you will receive when the exam is finished.

Please complete this questionnaire carefully at home and bring it with you on the day of your exam. We are aware that this often requires spending a considerable effort consulting your personal medical records. The data in the questionnaire nevertheless constitute an essential part of the initial exam that you will undergo at our centre; during further visits of yours these efforts will be greatly simplified.

IF YOU ARE GOING ABROAD

- ✓ Be sure to complete the "vaccination" section of this questionnaire carefully!!!
- ✓ What country are you traveling to/staying in?
- ✓ How long will you be staying in this country/these countries?
- ✓ Are you using a prophylactic treatment for malaria?
- ✓ Have you already arranged a medical check-up for when you temporarily or definitively return from your stay abroad?

Family name (surname) :
Married name:
Given names :
Gender :
Address :
Home telephone/ GSM :
Work telephone :
Email address :
Date of birth :
Nationality :
Employer :
Profession :
General Practitioner/ G.P. doctor (name and address) :

FAMILY HISTORY

Type of relation	Age (or age when deceased)	State of health – illness(es)	Age when illness was first contracted	If deceased, cause of death
Father				
Mother				
Brother 1				
Brother 2				
Sister 1				
Sister 2				
Paternal family: Grandfather Grandmother Uncle 1 Uncle 2 Aunt 1 Aunt 2				
Maternal family: Grandfather Grandmother Uncle 1 Uncle 2 Aunt 1 Aunt 2				

In particular, consider:

- Sudden death, including sudden cardiac arrest and sudden cardiac death ……
- Myocardial infarction (heart attack);
- Angina pectoris (coronary insufficiency, coronary artery disease that required special treatment)
- Arteritis (an artery condition, inflammation of the artery walls)
- A cerebrovascular accident (CVA, stroke, thrombosis)
- High blood pressure
- Type 1 diabetes (juvenile diabetes, often treated with insulin injections)
- Type 2 diabetes (late onset, treated orally with medication)
- Gout (uric acid)
- Cancer, of – the breast – the prostate – the bowel/the colon – the lungs – the stomach – melanoma/skin cancer - other
- Glaucoma
- Deafness – or hard of hearing from birth
- Hyperthyroidism, overactive thyroid– hypothyroidism, underactive thyroid
- Asthma
- Auto-immune disorders, auto-immune disease (rheumatoid arthritis, lupus ….)
- Coagulation problems (bleeding or clotting problems)
- Mental health problems, suicide

PERSONAL MEDICAL HISTORY

Have you ever suffered from /or been hospitalised because of: *(please tick off the appropriate box and state the year of the event)*	*In which year?*
☐ A pulmonary disease (asthma, chronic bronchitis …..)	
☐ A ENT disease (Ear, Nose or Throat)	
☐ A heart condition	
☐ A vascular disease (arteritis, thrombophlebitis, embolism …)	
☐ A neurological disorder (migraine, epilepsy ….)	
☐ A gastro-intestinal disorder	
☐ A renal or urinary disease (prostate, bladder, urinary stone……	
☐ Liver disease, liver damage	
☐ An endocrine disease (diabetes, thyroid gland ……)	
☐ Infectious diseases	
☐ Osteo-articular disorders: bone fracture, ligament- ,muscular- or joint injury, osteoporosis, osteopenia ?	
☐ Haematological disease: (anaemia, transfusion, blood disease …..)	
☐ An ophthalmologic disorder (glaucoma, cataract ….)	
☐ Birth defects, congenital malformations	
☐ Lymph node disease	
☐ Mental health problems	
☐ Have you ever been unable to work for health reasons for more than 15 days?	
☐ Have you ever been treated with: o Chemotherapy? o Radiotherapy? o Hormones?	
☐ Have you ever suffered an accident?	
☐ In any previous check-up, has anyone ever communicated that something might be the matter, that something might be a problem?	
☐ Have you ever stayed in any tropical countries? If so, which ones?	
☐ Others	

PERSONAL SURGICAL HISTORY

Have you ever been operated on because of the following? : *In which year?*

(please tick off the appropriate box and state the year of the event)

☐ A lung condition	
☐ ENT disease (Ear, Nose or Throat)	
☐ A condition of the heart, arteries and veins (cardiovascular diseases)	
☐ A neurological condition	
☐ A gastro-intestinal condition (appendix, liver, gall bladder ….)	
☐ Renal disease or a urinary condition (prostate, bladder)	
☐ An endocrine disease (thyroid gland ……)	
☐ An orthopaedic condition or traumatic injury	
☐ An ophthalmologic condition (refractive surgery, cataract, glaucoma….)	
☐ Congenital malformations	
☐ Others	

GYNAECOLOGICAL HISTORY

(please tick off the appropriate box and state the year of the event or answer the question)

☐ Age when you had your first period? ☐ How many pregnancies have you had? (Miscarriages and potential interruptions of pregnancies included)? ☐ Age when you had your first pregnancy? ☐ Were the pregnancies free from complications? ☐ In which year(s) did you give birth? ☐ Were the deliveries free from complications? ☐ Do you use any form of contraception: a contraceptive pill – hormone-free IUD (hormone-free Intra-Uterine Device) – hormonal IUD – tubal ligation – condoms – other? ☐ Do you have periods which are… o Normal? o Irregular? o Frequent? o Long? ☐ What date was … o Your last period?	

○ Your last mammogram? ○ Your last gynaecological smear test? ▯ If you have reached menopause, at what age did you reach it? ▯ Are you taking or have you taken hormone replacement therapy and if so, for how long? ▯ Have you ever suffered from and/or been admitted to hospital and/or had an operation for a gynaecologic complaint, disease or disorder? In which year?	

ALLERGIES

(please tick off the appropriate box and state the year of the event and give some comment if necessary)

Have you ever had one of the following allergies?

- ▯ Allergy to medication or medical materials?
- ▯ Food allergy?
- ▯ Respiratory allergy?
- ▯ Allergic rhinitis? Hay fever?
- ▯ Dermal allergy?
- ▯ Allergic reaction to an insect bite or to an insect sting?
- ▯ Quincke oedema
- ▯ Other allergic reaction

- ▯ Have you already undergone tests for allergic reactions?

TREATMENTS AND MEDICATION

What medications do you take **regularly**?

Name	Dosage(mg)	Number of times taken per day	Since when?

What medications do you take **occasionally** ?

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

In particular, consider:

- Sleeping tablets ?
- Tranquilisers ?
- Antidepressants ?
- Antihypertensives ?
- Medication for the heart ?
- Medication for the digestive system ?
- Contraceptives ?
- Food supplements (vitamine D, calcium ….)?

Are you receiving/do you sometimes receive the following treatment?
(please tick off the appropriate box and give some comment if necessary)

- ☐ Physiotherapy
- ☐ Osteopathy
- ☐ The wearing of support stockings
- ☐ Hearing aids
- ☐ Orthopaedic (in-)soles
- ☐ Pacemaker
- ☐ Device to treat Obstructive Sleep Apnoea (CPAP)
- ☐ Other medical equipment?

What vaccines have you had? **Or, better: bring your immunisation card !!!!**

Type	*Date of the last dose*	*Total number of doses*
Tetanus		
Diphtheria		
Pertussis/whooping cough		
Pneumococcal disease		
Flu/influenza		
Hepatitis A		
Hepatitis B		
Polio		
Meningitis A,C,W,Y		
Typhoid fever		
Rabies		
Yellow fever		
Other :		

HEALTHINESS OF LIFESTYLE

(please tick off the appropriate box / underline and give necessary details)

Do you smoke? cigarettes – cigars – cigarillos – a pipe - cannabis

- How many cigarettes per day and since when did you start?
- Have you ever tried to quit smoking?

Do you do physical exercise?

- What sort?
- How many hours, in total, per week?

Eating:

- Do you consume dairy products? How many times a day? – 1x per day - occasionally
- How many portions (of 100 grams each) of fruits and/or vegetables per day?
- Do you eat fish? Several times per week? – 1x per week – occasionally
- How many times per week do you eat red meat, including beef and pork products?
- How many cups or glasses of caffeinated drinks (coffee, tea and cola) do you drink per day?
- How many glasses of a drink with alcoholic content do you drink per day – per week – occasionally?
- Are you on a special diet?
  - ◊ A low cholesterol diet?
  - ◊ A low sugar diet?
  - ◊ A vegetarian diet?
  - ◊ A vegan diet?
  - ◊ A low sodium diet ?

Do you have a food intolerance that has been confirmed by medical tests?

- Lactose intolerance
- Gluten intolerance
- Other

GENERAL QUESTIONS

(please tick off the appropriate box and give some comment if necessary)

- ☐ Do you consider yourself to be in poor health?
- ☐ Are you sleeping badly?
- ☐ Do you feel an unexplained or unhabitual tiredness?
- ☐ Have you been losing weight or putting on weight? How much, in kilograms, and during what period of time?
- ☐ Have you experienced a loss of appetite recently?
- ☐ Do you sometimes have a fever without apparent cause?
- ☐ Do you sometimes experience unexplained pains?
- ☐ Are you sweating abnormally?
- ☐ Have you been feeling more irritable than normal lately?
- ☐ Do you use (or have you used) drugs?
- ☐ Are you working on a part-time basis?
- ☐ Do you feel socially isolated?
- ☐ Do you have a hobby?

HEART AND CIRCULATION SYSTEMS AND PULMONARY SYSTEM

- ☐ Do you get short of breath…
  - ◊ When resting?
  - ◊ When exerting yourself ?
  - ◊ At night?
  - ◊ After meals?
- ☐ Do you feel a oppressing feeling in or pain in your chest?
- ☐ Do you feel heart palpitations?
- ☐ Do you often get swellings in your feet?
- ☐ Do you feel pain in your legs when you walk?
- ☐ Do your legs feel heavy?
- ☐ Do you suffer from varicose veins?
- ☐ Are your fingers often white, blue or painful?
- ☐ Do you cough regularly, with or without expectorations (coloured, or coughing up blood)?
- ☐ Is your breathing sometimes with a wheeze?

DIGESTIVE SYSTEM

- Do you often experience stomach pains?
- Do you often feel nauseous or vomit?
- Do you have problems with your digestion?
  - heaviness
  - feeling bloated, gassy
- Do you suffer from acid reflux (« a burning sensation »)? How often?
- Do you have problems in the passing of your stools?
  - constipation – diarrhoea – alternating between the two
  - Irregular motions?
  - Blood in your stools?
  - Black stools?
  - Anything else unusual?
- Do you suffer from haemorrhoids?
- What was the date of your last colonoscopy, and what was the result?

URO-GENITAL SYSTEM

(please tick off the appropriate box and give some comment if necessary)

For men:

With regards to the prostate:

- Have you ever had the feeling that your bladder was not completely empty after urinating?
- Do you need to urinate within two hours of the last urination?
- Have you experienced interruption in the flow of urine, that is to say starting and stopping in the passage of urine?
- Have you experienced difficulty retaining urine ?
- Have you experienced a drop in the volume or in the force of the flow of your urine?
- Have you had to exert yourself, to force yourself, to start to urinate?
- How many times per night, on average, do you have to get up to urinate?

Are your testicles

- painful?
- hardened?
- Have they changed in volume?

Other problems?

- Do you have any problems with your penis?
- Have you noticed blood in your urine?

For women:

- How many times per night, on average, do you have to get up to urinate?
- Have you noticed blood in your urine?
- Do you lose blood in between periods?
- Are your breasts painful before periods?
- Have you noticed any discharge from your breasts?
- Have you noticed the presence of a lump in your breast or under your arms?
- Have you noticed any abnormal vaginal discharge (in its smell or colour)?
- Has sexual intercourse been painful or problematic?
- Have you had problems in the vulva (itchy skin or ulceration)
- Have you experienced recurring urinary infections?
- Have you had leakages or experienced desperately needing to urinate suddenly?

NEUROLOGICAL SYSTEM

(please tick off the appropriate box and give some comment if necessary)

- Do you suffer from dizziness?
- Do you suffer from syncopes (fainting, loss of consciousness ?)
- Do you experience tingling in your limbs?
- Have you noticed a drop in your ability to feel sensations?
- Have you experienced a drop in your muscle strength?
- Do you shake ?
- Do you have difficulty :
    - Keeping your balance?
    - Speaking?
    - Remembering things?

- Do you suffer from headaches?
    - How often?
    - Have they come on recently or have they done so for a long time?
    - Do they occur at the same time as other symptoms (nausea, vomiting, feeling irritated by light, feeling irritated by sound)?

LOCOMOTOR APPARATUS/ MUSCULOSKELETAL SYSTEM

- Do you suffer from pain in your joints or morning stiffness?
- Do you suffer from back pain?
- Do you suffer from neck pain?
- Have you suffered from fractures?
- Do you experience muscle cramps?

EAR, NOSE and THROAT SYSTEM

- Hearing :
  - Do you experience buzzing in the ears, tinnitus?
  - Have you noticed a drop in your ability to hear things?
- Do you have any problems with your ears (any discharges)?
- Do you often experience nosebleeds?
- Do you experience chronically runny nose?
- Do you have problems with your lips, mouth, tongue or throat?
- Have you experienced hoarseness in your voice?
- Have you had problems swallowing?
- Do you snore with or without an apnoea?

DERMATOLOGY

- Do you consult a dermatologist regularly? How often?
- Do you have a problem with your skin?
- Do you have any birthmarks or moles which have changed recently?
- Are you losing hair?
- Do you experience rashes easily; do you often have itchy skin?

OPHTHALMOLOGY

- Do you have
  - Myopia
  - Hyperopia
  - Astigmatism
  - Presbyopia
- Does your eyesight require optical correction :
  - Which?: Glasses – contact lenses - other
  - How many dioptres? : Left eye : _____ Right eye : _____
- Do you feel a tension, a pain in your eyes?

- Do your eyes tingle?
- Have you noticed your eyesight diminish recently?
- Do you have problems seeing all colours?

HEMATO IMMUNOLOGICAL SYSTEM

(please tick off the appropriate box and give some comment if necessary)

- Do you bleed easily?
  - Nosebleeds
  - Bleeding gums
- Have you noticed any irregular appearance of lymph nodes recently?
- Have you ever shown signs of anaemia or of iron deficiency?
- Have you ever given blood?

	Never	Almost never	Sometimes	Fairly often	Very often
1. In the last month, how often have you been upset because of something that happened unexpectedly?	O	O	O	O	O
2. In the last month, how often have you felt that you were unable to control the important things in your life?	O	O	O	O	O
3. In the last month, how often have you felt nervous and "stressed"?	O	O	O	O	O
4. In the last month, how often have you felt confident about your ability to handle your personal problems?	O	O	O	O	O
5. In the last month, how often have you felt that things were going your way?	O	O	O	O	O
6. In the last month, how often have you found that you could not cope with all the things that you had to do?	O	O	O	O	O
7. In the last month, how often have you been able to control irritations in your life?	O	O	O	O	O
8. In the last month, how often have you felt that you were on top of things?	O	O	O	O	O
9. In the last month, how often have you been angered because of things that were outside your control?	O	O	O	O	O
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	O	O	O	O	O

Perceived Stress Scale (PSS 10)

This test is the simplest and the most widely used instrument to measure the perception of how much stress a given person thinks he or she is feeling. The result, in any case, does not have any diagnostic value in medical testing. It allows certain information to be gathered concerning the ability you have to change

aspects of your professional or personal life, and, if this is found to be a low ability, it recommends that you seek medical treatment or psychotherapy.

This test should not take you very long. Answer the questions quickly and as spontaneously as possible. The questions are about how you have been feeling over the course of the past month.