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Name:

**Date of Birth:**

Health is your most valuable asset. Early diagnosis of key individual risk factors provides us with the most powerful tools for the prevention of serious illness.

**Your appointment to discuss your current state of health is confirmed with Dr. R. Giugliano.**

To make the most of your time with the doctor, we kindly ask you to complete electronically **the following questionnaire** and **return it to us by email.**

If you are an existing patient, some of the information may already be known to us. However, it is preferable to complete this form in full, as some data might be out of date. This is will also ensure that no indications have been overlooked.

**When saving the document, please:**

* don’t worry about formatting or fields extending onto the following pages.
* You can click on , in order to mark them. In text boxes (such as      ), you can type any additional information by clicking on them.

Please carefully read your policy conditions to learn if your insurance covers the health check, and on which conditions.

Finally, please keep in mind that you will be asked to pay after the health check and then you can send the invoice to your Insurance company in order to get reimbursed.

Should you have any questions prior to your appointment, please do not hesitate to contact us directly.

We thank you in advance for taking the time to improve your life and allowing us the opportunity to play a part in it!

Best regards,

Preventive Health Care Team

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**MEDICAL QUESTIONNAIRE**

Privacy disclosure: All details contained within and surrounding this questionnaire are strictly confidential and will not be shared with third parties unless authorised by the patient. Your answers will help us understand better your medical problems. This questionnaire will become part of your confidential medical record.

*I am aware that any falsified or incomplete information on this form may cause the results of this medical health check to be considered null and void and, therefore, the details included in this document are true and accurate to the best of my knowledge.*

*I agree and therefore will proceed with completing the questionnaire and the scheduled appointment*

*I do not agree and will contact the IHCH to cancel my appointment*

Name: DOB: Age: Gender:

**PAST MEDICAL HISTORY FAMILY HISTORY**

Do you now or have you ever had? Does anyone in your family has or ever had?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | Details |  | Relation | Age it occurred | Details |
|  | High Blood Pressure |  | yesno |  |  |  |
|  | Heart Problems |  | yesno |  |  |  |
|  | Heart Attack |  | yesno |  |  |  |
|  | Diabetes | Type I Type II | yesno |  |  |  |
|  | Elevated Cholesterol/Lipids |  | yesno |  |  |  |
|  | Stroke |  | yesno |  |  |  |
|  | Blood clots in the legs |  | yesno |  |  |  |
|  | Ovarian cancer |  | yesno |  |  |  |
|  | Breast cancer |  | yesno |  |  |  |
|  | Colon cancer |  | yesno |  |  |  |
|  | Other cancer |  | yesno |  |  |  |
|  | Leukemia |  | yesno |  |  |  |
|  | Autoimmune disease |  | yesno |  |  |  |
|  | Liver Disease |  | yesno |  |  |  |
|  | Gall bladder problems |  | yesno |  |  |  |
|  | Kidney/Bladder Problems |  | yesno |  |  |  |
|  | Anemia/Blood Disorders |  | yesno |  |  |  |
|  | Asthma/Emphysema |  | yesno |  |  |  |
|  | Neurological Disorder |  | yesno |  |  |  |
|  | Epilepsy (seizures) |  | yesno |  |  |  |
|  | Glaucoma |  | yesno |  |  |  |
|  | Osteoporosis/ Hip fracture |  | yesno |  |  |  |
|  | Arthritis/Joint Problems |  | yesno |  |  |  |
|  | Thyroid/Endocrine Problems |  | yesno |  |  |  |
|  | Psychiatric problems |  | yesno |  |  |  |
|  | Gastrointestinal Problems |  | yesno |  |  |  |
|  | Skin Problems |  | yesno |  |  |  |
|  | Sleep problems |  | yesno |  |  |  |
|  | Infectious disease |  | yesno |  |  |  |
|  | STD (sexually transmitted disease) |  | yesno |  |  |  |
|  | TB (Tuberculosis) |  | yesno |  |  |  |
|  | Pneumonia |  | yesno |  |  |  |
|  | Psoriasis |  | yesno |  |  |  |
|  | Hepatitis |  | yesno |  |  |  |
|  | HIV |  | yesno |  |  |  |
|  | Other |  | yesno |  |  |  |

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**PAST MEDICAL HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| Surgical Procedures | Year and Where | Hospitalizations | Year and Where |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**REGULAR MEDICATIONS** (including prescription drugs, over the counter drugs(OTC), birth-control pills, vitamins, food supplements)

|  |  |  |
| --- | --- | --- |
| Medication | Dosage | Frequency |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**ALLERGIES**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| To medications |  |  |  |  |
| Other allergies |  |  |  |  |

**GYNAECOLOGICAL HISTORY**

|  |  |
| --- | --- |
| Are you still menstruating? | Yes  No If no, the reason is:  Natural menopause Hysterectomy Other :       Do not know |
| Are you pregnant at the moment? | Yes  No |
| Have you ever had a miscarriage? | Yes  No |
| Number of children |  |
| Gynaecological surgeries | Yes  No If yes, please specify: |
| Current birth-control method |  |
| Date of last Pap-smear |  |
| Date of last mammogram |  |

**PERSONAL AND SOCIAL HISTORY**

|  |  |
| --- | --- |
| Have you ever had a serious accident? | Yes  No If yes, please specify: |
| Have you taken any psychoactive drugs in the last 5 years? | Yes  No If yes, please specify: |
| Is your life stressful? | Yes  No If yes, please specify: |
| Do you currently smoke? | Yes  No If yes,       cigarettes/day for       years |
| Have you ever smoked? | Yes  No If yes,       cigarettes/day for       years |
| Are you exposed to secondhand smoke? | Yes  No If yes, please specify: |
| Do you drink alcohol? | Yes  No If yes:      units of alcohol per |
| Do you drink coffee? | Yes  No If yes:       cups/day |
| Do you drink tea? | Yes  No If yes:       cups/day |
| Do you exercise regularly? | Yes  No If yes:       times/week  Type of exercise: |
| How many pieces of fruit and vegetables do you eat per day? |  |
| How many times/week do you eat fish? |  |
| How many times/week do you eat meat? |  |

**IMMUNIZATION HISTORY**

|  |  |
| --- | --- |
| Have you completed your immunization program as a child? |  |
| When was the date of your last vaccination?  What vaccination was that? |  |
| Have you ever been vaccinated for hepatitis B?  If yes, was a series of 3 injections occurred? |  |
| Do you travel often? Where? |  |



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**SYSTEMS REVIEW** (Check if you have or have had any of the following in the past 3 months)

|  |  |  |
| --- | --- | --- |
| **GENERAL** | **GASTROINTESTINAL SYSTEM** | **LIMBS** |
| recent (in the last year) weight gain, | nausea/vomiting | hand reaction in cold |
| how much | stomach ache | swollen fingers |
| recent (in the last year) weight loss, | food intolerance | wrist pain |
| how much | bloating | hand pain |
| fatigue/ feeling often tired | abdominal pain | arm pain |
| weakness | dyspepsia/pain related to eating | swollen legs/feet |
| fever | excessive gas | cold legs/ feet |
| night sweats | indigestion, heart burn | leg muscle discomfort |
|  | constipation | lower leg pain while walking |
| **HEAD/NEUROLOGIC** | yellow jaundice | leg weakness/ numbness |
| headache (more than twice a month) | diarrhoea | calf pain |
| dizziness | blood in stools | sores that will not heal |
| fainting | black stools |  |
| paralysis or weakness of limps |  |  |
| numbness/tingling where? | **KIDNEY/ BLADDER** | **PSHYCHIATRIC** |
| memory loss | frequent urination | excessive worries |
| tremor/ shakes | painful urination/burning sensation | difficulty falling asleep |
| poor coordination | urinary urgency | difficulty staying asleep |
| difficulty in speech | getting up at night to urinate | appetite loss |
| history of head injury | If yes, how many times? | food cravings |
|  | blood in urine | bulimia |
| **EYES** | difficulty urinating | frequent crying |
| seeing double | leakage or dribbling of urine | high stress levels |
| dark spots | frequent urinary infections | panic/anxiety attacks |
| flashing lights before your eyes | kidney stones | burn out syndrome |
| pain | lumps in genital area | phobias |
| redness | prostate problems | irritability |
| recent change of eyesight | sexual difficulties | sensitivity |
| blurred vision |  | poor concentration |
| cataracts | **GYNAECOLOGICAL** | racing thoughts |
| dryness | abnormal PAP-smear | rapid speech |
|  | irregular periods | anxiety |
| **ENT (EAR, NOSE, THROAT)** | bleeding between periods | guilty thoughts |
| ringing | pain during intercourse | risky behaviour |
| hearing loss | vaginal/pelvic discomfort | hallucinations |
| nose bleed |  | depression |
| hay fever/ nasal congestion | **SKIN/HAIR** | thoughts of suicide |
| sinus infection | rashes | paranoia |
| frequent sore throats | redness |  |
| difficulty swallowing | acne |  |
| pain in jaw | nodules/bumps |  |
| hoarseness | itching where? |  |
|  | skin cancer |  |
| **HEART AND LUNGS** | colour changes of hands and feet |  |
| angina/chest pain | hair loss |  |
| heart attack |  |  |
| murmurs | **MUSCLES/BONES/JOINTS** |  |
| palpitations | muscle pain |  |
| heart failure | decreased muscle strength |  |
| shortness of breath | back pain |  |
| shortness of breath after climbing stairs | neck pain/stiffness |  |
| cough (more than 4 weeks) | joint pain/stiffness |  |
| coughing up blood | joint swelling/redness |  |
| asthma |  |  |
| wheezing |  |  |
| emphysema/ chronic bronchitis |  |  |
|  |  |  |
| Other important information or concerns that have not been already illustrated? | |  |
|  | |  |