

HEALTH SCREENING QUESTIONNAIRE

Strictly confidential

The following questionnaire is an important part of your medical.

Before arriving for your health assessment we would be grateful if you would complete the following questionnaire as far as possible and bring it with you to your appointment to discuss with the doctor. Alternatively you may like to email the completed questionnaire back to us ready for your appointment.

Don't worry if there are questions that you can't answer as these can be discussed during the assessment.

Note to previous patients: If you have had a medical in the last 2 years with Dr Kelly and Associates you need only complete the new areas of information or information that was not given at your last medical.

PERSONAL DETAILS PLEASE PRINT CLEARLY

.....		
Surname		First	Middle		
Male <input type="checkbox"/>	Female <input type="checkbox"/>	GPs name and address:			
Marital Status:		Tel No:			
Date of Birth:		Please indicate if you would like a copy of your results to be sent to your GP?			
Cost Code (if applicable):		No <input type="checkbox"/>	Yes <input type="checkbox"/>		
Home Address & Post Code			Contact Telephone Numbers		
			Home:		
			Daytime:		
			Mobile:		
			Email:		
NEXT OF KIN:			Address:		
Name:					
Relationship:			Telephone number:		

Please indicate whether you would like a chaperone to be present during the examination?

Yes

No

YOUR OCCUPATION

Company Name: Company Address:	Job title or role:
What are your typical working hours?	
What percentage of the working day do you estimate you spend at the computer?	
Do you travel internationally for work? If so, how frequently?	
What percentage of international work travel involves flights longer than 4 hours (actual flight time)?	

FAMILY HISTORY

Please give the current age and state of health of the following relatives, or if deceased, their age and the cause of death	
Father:	Spouse:
Mother:	Children:
Brothers:	Sisters
Is there a family history of any of the following (Grandparents, parents, brothers, sisters)? If appropriate please provide details.	
Heart Disease	High Blood Pressure
Stroke	High Cholesterol
Diabetes	Any cancers
Mental Health Problems	Glaucoma
Blood clots	Asthma
Arthritis	Any other hereditary conditions
Details:	

LIFESTYLE ISSUES

How many times per week do you exercise?

How much brisk walking do you do per day?

Do you smoke?

If yes, estimated number per day?

If infrequent smoker, number per week?

How much alcohol do you drink on average per week in units?

(1 unit is equivalent to 1 small glass of wine, ½ a pint of beer or lager or a short of spirit)

Do you have a special diet? If yes, please give details.

Do you estimate that you eat 5 portions per day of fruit and vegetables?

Have you ever had raised cholesterol?

Do you take any vitamin/mineral supplements?

YOUR HEALTH

Do you have diabetes, thyroid problem, arthritis, asthma, depression or any diagnosed medical illness?

If Yes, please give details.

Have you had any medical treatment or investigations in the past six months?

Are you awaiting a specialist appointment?

Are you on any medication, including the contraceptive pill or non-prescribed medication, at the moment?

If Yes, please give details

Do you have any allergies to medication or other substances?

If Yes, please give details.

How many sickness days do you estimate that you have taken from work in the past two years?

Have you ever had or do you think you may have any work-related illness or condition?

If Yes, please give details.

Do you have any health concerns that you would particularly like to discuss with the doctor at the medical?

If Yes, please give details.

Have you ever been in hospital? (please give details of approximately when and what for).

SYMPTOM CHECKLIST

Please look at the symptom check list below and circle any issues that you have had problems with in the past or currently:

1. Chest problems such as coughing, wheezing, breathlessness, coughing blood or sputum, chest pain, chest tightness, palpitations?
2. Abdominal symptoms such as indigestion, heartburn, nausea, vomiting, diarrhoea, constipation, blood in the stools, black stools, abdominal pain?
3. Loss of weight, loss of appetite?
4. High blood pressure?
5. Urinary problems such as pain on passing urine, discharge, passing urine more frequently, discoloured urine, blood in the urine, incontinence or , (in men) changes in the urinary stream such as dribbling, poor flow?
6. Skin rashes, unusual moles, eczema, psoriasis?
7. Faints, seizures, dizzy spells, unusual headaches, co-ordination problems, limb weakness?
8. Mood change, irritability, aggression, insomnia, anxiety, panic attacks, stress (see also later section)?
9. Problems with your vision or hearing, other problems with ears or eyes?
10. Breast lumps or pain?
11. Problems with muscles, tendons, joints? Back problems?
12. (Ladies only)Gynaecological problems such as irregular periods, very heavy periods, bleeding between periods or after intercourse, vaginal discharge?

For Women Only:

Please give the approximate date of your last cervical smear test?

Have you had any abnormal cervical smear tests? Yes No

If "yes" please provide details

Have you had any abnormal pregnancies or complications of pregnancy? Yes No

If "yes" please specify.....

STRESS (In association with Healthy Mind, Dr George John MB BS FRCPsych)

A certain amount of stress is inevitable in all our lives. Indeed the adrenaline buzz is something that enables us to function efficiently. However, excess stress can have an adverse effect on our health and functional level. Some people do not realise when their health is being adversely affected. They may be tired and irritable, shouting at their partner or children, or sleeping poorly with early morning wakening. Their appetite may be poor or they may 'comfort eat'. They may become withdrawn and start to drink alcohol excessively or take 'recreational' drugs. As part of your health assessment we would like to try to get some idea of your stress levels and how you are coping with them. The questionnaire is designed to highlight areas for possible discussion with the Doctor. It is treated in the strictest confidence.

Please complete the following questions by marking an "X" on the scale between 1-10.

1. How would you rate your current stress level?

No Stress Very High Stress
1 10

2. How well do you think you cope with personal stress levels?

Cope well Cope badly
1 10

3. In general how would you describe your mood (how do you feel)?

Happy Sad
1 10

4. Do you feel in control of your life?

Yes Not at all
1 10

5. Are you having problems at work?

No Sometimes
1 10

6. Do you sleep badly?

Never Often
1 10

7. Do you worry about work?

Never Often
1 10

8. Do you take your frustration out on family and/or friends?

Never Often
1 10

9. Do you have family problems (marital, children, etc)?

Never Often
1 10

10. Do you find enough time in the day to relax?

Yes Not at all
1 10

11. Do you feel that stress is affecting work/home?

Never Often
1 10

12. Do you feel you need help?

Never Often
1 10

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE