The Holly
PRIVATE HOSPITAL

Health screening questionnaire

High Road
Buckhurst Hill
Essex IG9 5HX

Tel: 020 8936 1202
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Visit: theholly.com

Title: _____ Surname: _____

Forenames: _____

Date of birth: _____ Age: _____

Address: _____

_____

_____

_____

Tel no. (Home): _____

Tel no. (Work): _____

Tel no. (Mobile): _____

Marital status: _____ No. of children: _____

GP name: _____

GP address: _____

_____

_____

Would you like an extra copy of your health screening report for your GP? ☐ Yes ☐ No

Would you like us to remind you when your next health screen is due?? ☐ Yes ☐ No

Patient details

1. Lifestyle and occupation

Smoking habits:

☐ Never ☐ Occasionally ☐ Regularly ☐ Ex-smoker - date stopped

How long did you smoke? _____

Current smoker - how many per day? _____

Exercise:

How many hours do you exercise, including walking, for 30 mins or more each week?

☐ Never ☐ Once ☐ Twice ☐ Three times or more

Describe your activities _____

Alcohol intake:

On average, how many units of alcohol do you drink per week? _____

(1 unit = 1/2 pint beer or cider, a single measure of spirits, 1 glass of wine)

Diet:

Do you have a restricted diet? ☐ Yes ☐ No

Describe your usual diet _____

Occupation:

Title _____

Job description _____

Do you have any concerns regarding your work or working environment?

_____

2. Family history

Is your father alive? ☐ Yes ☐ No If yes, how old is he? _____

Relevant medical conditions - past and present _____

_____

If no, age and cause of death _____

Is your mother alive? ☐ Yes ☐ No If yes, how old is she? _____

Relevant medical conditions - past and present _____

_____

If no, age and cause of death _____

How many brothers or sisters do you have? _____

Are they alive? ☐ Yes ☐ No If yes, how old are they? _____

Relevant medical conditions - past and present _____

_____

If no, age and cause of death _____

Leave for doctor's comments

3. Your past medical and surgical history

Please tick any disease you have suffered from/are currently suffering from in the first box, and the age of onset in the second box e.g. Anxiety ☐ 33

	Yes	Age
Angina	☐	
High blood pressure	☐	
Heart attack	☐	
Other heart disease	☐	
Stroke	☐	
Phlebitis	☐	
Rheumatic fever	☐	
Varicose veins	☐	
Blood disorder	☐	
Shortness of breath	☐	
Hay fever	☐	
Bronchitis	☐	
Asthma	☐	
Tuberculosis	☐	
Pneumonia	☐	
Pleurisy	☐	
Throat problems	☐	
Indigestion	☐	
Duodenal ulcer	☐	
Gastric ulcer	☐	
Hiatus hernia	☐	
Gall stones	☐	
Hepatitis or jaundice	☐	
Diarrhoea or vomiting	☐	
Constipation	☐	
Polyps in the colon	☐	
Inguinal hernia	☐	
Prostate/bladder problems	☐	
Kidney stones	☐	
Kidney infection	☐	
Cystitis	☐	
Thyroid gland disorder	☐	
Diabetes	☐	
Other glandular disorders	☐	
Typhoid	☐	
Malaria	☐	
Other tropical diseases	☐	

	Yes	Age
Anxiety	☐	
Depression	☐	
Sleep problems	☐	
Black outs or fits	☐	
Epilepsy	☐	
Headaches or migraine	☐	
Concussion or head injury	☐	
Cancer	☐	
Type		
Skin problems	☐	
Allergies	☐	
Unsightly scars or tattoos	☐	
Nasal problems or discharge	☐	
Ear disease or discharge	☐	
Defective vision	☐	
Cataracts	☐	
Glaucoma	☐	
Conjunctivitis	☐	
Troublesome backache	☐	
Arthritis	☐	
Rheumatism	☐	
Muscle or nerve disease	☐	
Syphilis	☐	
Gonorrhoea	☐	
Chlamydia	☐	
Other sexual problems	☐	
Whooping cough	☐	
Measles	☐	
Mumps	☐	
Scarlet fever	☐	
Diphtheria	☐	
Meningitis	☐	
Radiation treatment	☐	
Radiation sickness	☐	

Other illnesses suffered _____

_____

_____

Please list any accidents or operations _____

_____

_____

Leave for doctor's comments

4. This section is for females only

Leave for doctor's comments

Family history:

Have you ever had or have now any breast problems? ☐ Yes ☐ No

Please give details _____

_____

Date of last Mammogram (breast X-Ray) _____

Obstetric history:

No. of pregnancies, stillbirths, miscarriages or terminations of pregnancy

Date	Type	Sex M/F	Birth weight	Method of delivery
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Comments _____

_____

Menstrual history:

At what age did your periods begin? _____ years

Date of last period _____

Date of last cervical smear if any? _____

Was it normal? ☐ Yes ☐ No

If no, did you have further treatment? Please describe _____

_____

How many days do your periods usually last? _____

How often do you usually have a period? every _____ days

Do you usually spot or bleed between periods? ☐ Yes ☐ No

In the last 6 months have your periods been regular? ☐ Yes ☐ No

If you have reached the menopause what was the date? _____

Did they stop naturally? ☐ Yes ☐ No

Or after an operation? ☐ Yes ☐ No

Have you had any bleeding since? ☐ Yes ☐ No

Do you have any hot flushes or sweats? ☐ Yes ☐ No

Have you ever had Hormone Replacement Therapy (HRT)? ☐ Yes ☐ No

If so what? _____

Contraception:

Are you sexually active? ☐ Yes ☐ No

Which method of contraception are you using? _____

For how long have you used it? _____ months/years

Have you used other forms of contraception? ☐ Yes ☐ No

If yes, which method and for how long? _____

Have you had any gynaecological operations or investigations? ☐ Yes ☐ No

If yes, please give details _____

Present Pelvic Symptoms:

Have you any troublesome vaginal discharge?	☐ Yes	☐ No
Do you have pain or soreness during or after intercourse?	☐ Yes	☐ No
Is there any bleeding after intercourse?	☐ Yes	☐ No
Do you have any difficulty pasing or controlling urine?	☐ Yes	☐ No
Do you have any problems with your bowels?	☐ Yes	☐ No
Do you have pain or discomfort in your abdomen?	☐ Yes	☐ No

The female section of the questionnaire has now been completed.

5. Current medical concerns

Are there any general or specific comments you would like to make with regard to your health? _____

_____

_____

Would you please list any current treatment(s) or medication you are taking:

_____

_____

_____

Finally, may we ask what prompted you to come for a health screen?

_____

_____

_____

The rest of this questionnaire will be completed by the doctor.
Don't forget you have the opportunity to discuss any of your answers during your consultation with the doctor.

Leave for doctor's comments

Doctor's comments - findings

Clinical examination _____

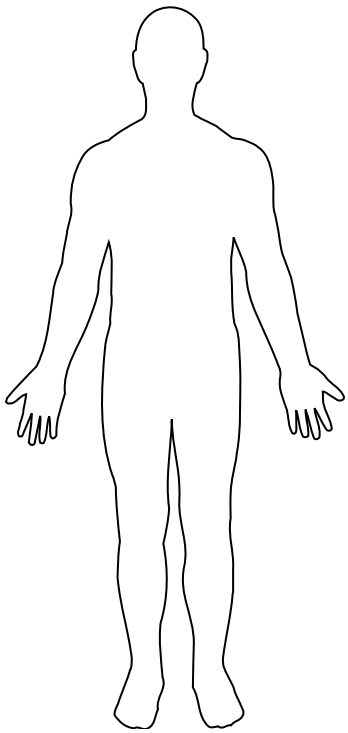
Reminder listing _____

Height _____

Weight _____

Urine _____

Body Mass Index _____



Doctor's comments - findings continued

Advice and recommendations

Consent form: _____ Signed/unsigned

Pre-employment result: ☐ Fit for the job ☐ Limited duties only ☐ Failed

Report for ☐ Patient ☐ GP ☐ Company Medical Officer ☐ Layman

Next recommended health screen: ☐ 1 year ☐ 2 years ☐ 3 years

Doctor's name: _____

Signature: _____

Date: _____

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