MEDICAL QUESTIONNAIRE (female)

Slievemore Clinic,
Old Dublin Road,
Stillorgan,
Co. Dublin.
Tel 01-2000501

The appointment comprises of a discussion about this questionnaire and a subsequent medical examination. You will receive a written report based on the doctors findings, usually between three to four weeks later.

- In order for the examination to be as comprehensive as possible, please fill out this detailed questionnaire at home and give to your doctor **on the day of your consultation.** Do not worry if you have difficulty understanding the questions. Leave any blanks if you so desire.

- Special time is allocated for this test and patients are requested to cancel well in advance if they do not intend to attend.

- PLEASE FAST (ie. NO FOOD OR FLUIDS) FOR THE **14 HOURS** BEFORE YOUR APPOINTMENT, FOR ACCURATE BLOOD TESTING.

- Do not apply lotions or creams on your body on the day of your appointment.

PERSONAL DETAILS

NAME:

DATE OF BIRTH: _____/_____/19_____

ADDRESS:

IS THIS YOUR FIRST MEDICAL CHECK-UP ? :

OCCUPATION:

EMPLOYER:

MARITAL STATUS:

NO. OF CHILDREN:

FAMILY STATE OF HEALTH (if living) / CAUSE OF DEATH (if dead)

FATHER:

MOTHER:

BROTHERS:

SISTERS:

(ESPECIALLY NOTE ANY CANCER, HEART CONDITIONS, DIABETES OR ASTHMA)

PAST MEDICAL HISTORY

PLEASE DETAIL ALL YOUR HOSPITAL ADMISSIONS ACCORDING TO YEAR AND TREATMENT GIVEN. (Use the back of this page if required).

PLEASE DETAIL ANY OTHER OF YOUR MEDICAL CONDITIONS :

HAVE YOU EVER REQUIRED SPECIAL INVESTIGATIONS (eg. X-rays, blood tests)?

PLEASE LIST ANY ALLERGIES THAT YOU HAVE:

PLEASE LIST ALL YOUR MEDICATIONS/PILLS/INHALERS:

DO YOU SMOKE? YES / NO
IF "YES", IN WHAT FORM AND HOW OFTEN?
IF "NO", HAVE YOU EVER SMOKED IN THE PAST?

DO YOU DRINK ALCOHOL? YES / NO
IF "YES", IN WHAT FORM AND WHAT WEEKLY QUANTITY?

ARE YOU INVOLVED IN REGULAR EXERCISE? YES / NO
IF "YES", HOW OFTEN PER WEEK?

CENTRAL NERVOUS SYSTEM.

DO YOU SUFFER FROM FREQUENT HEADACHES? YES / NO
DO YOU WEAR GLASSES? YES / NO
ARE YOU COLOUR-BLIND? YES / NO

DO YOU HAVE - ANY PROBLEMS WITH YOUR VISION? YES / NO
- ANY SPEECH PROBLEM? YES / NO
- ANY MUSCLE WEAKNESS? YES / NO
- ANY WASTING OF MUSCLES? YES / NO
- ANY NUMBNESS IN YOUR BODY? YES / NO
- ANY MUSCLE TWITCHES OR SPASMS? YES / NO
- MEMORY PROBLEMS? YES / NO
HAVE YOU EVER - HAD A FIT? YES / NO
- BEEN UNCONSCIOUS? YES / NO
- FAINTED? YES / NO

PSYCHOLOGICAL ASPECTS

DO YOU SUFFER FROM - DEPRESSION? YES / NO
- A LACK OF INTEREST IN EVERYTHING? YES / NO
- STRESS? YES / NO
- FEELINGS OF PANIC? YES / NO
DO YOU HAVE - ANXIETIES (eg. PERSONAL, DOMESTIC OR CAREER)? YES / NO
- ANY FEARS? YES / NO
- DIFFICULTY SLEEPING? YES / NO
- POOR LEVELS OF CONCENTRATION? YES / NO
HAVE YOU EVER - FELT GUILTY ABOUT YOUR DRINKING HABITS? YES / NO
- FELT THE NEED TO CUT DOWN ON DRINKING? YES / NO
- BEEN A PATIENT IN A PSYCHIATRIC HOSPITAL? YES / NO
- BEEN TREATED FOR SCHIZOPHRENIA? YES / NO
- FELT LIKE HARMING YOURSELF? YES / NO

CARDIOVASCULAR SYSTEM

DO YOU SUFFER FROM CHEST PAINS? YES / NO
HAVE YOU EVER HAD HIGH BLOOD PRESSURE? YES / NO

DO YOU OFTEN FEEL LIKE FAINTING? YES / NO
DO YOU GET - SHORT OF BREATH EASILY? YES / NO
- SHORT OF BREATH WHEN LYING DOWN? YES / NO
- SHORT OF BREATH DURING THE NIGHT? YES / NO
- LEG CRAMPS WHEN WALKING? YES / NO
- LEG PAINS DURING THE NIGHT? YES / NO
- HEART PALPITATIONS? YES / NO
- SWOLLEN ANKLES? YES / NO

GENITO-URINARY SYSTEM

DO YOU HAVE - ANY DISCOMFORT PASSING WATER? YES / NO
- DIFFICULTY WITH YOUR STREAM? YES / NO
- TO GET UP AT NIGHT TO PASS URINE? YES / NO
- TO PASS WATER VERY FREQUENTLY? YES / NO
DO YOU OFTEN LOSE CONTROL OF YOUR BLADDER? YES / NO
HAVE YOU EVER - HAD ANY URINARY INFECTIONS? YES / NO
- SUFFERED FROM RENAL STONES? YES / NO
- HAD BLOOD IN YOUR URINE? YES / NO
- HAD A SEXUALLY TRANSMITTED DISEASE? YES / NO
DO YOU HAVE - ANY SEXUAL PROBLEMS? YES / NO
- A LOSS IN LIBIDO? YES / NO
DO YOU SUFFER FROM - VAGINAL ITCHING? YES / NO
- VAGINAL DRYNESS? YES / NO
- PAINFUL INTERCOURSE? YES / NO

RESPIRATORY SYSTEM.

DO YOU - COUGH FREQUENTLY? YES / NO
- SUFFER FROM ASTHMA? YES / NO
- FIND IT DIFFICULT TO EXERCISE? YES / NO
- SNEEZE A LOT? YES / NO
- GET WHEEZY IN THE CHEST? YES / NO
HAVE YOU EVER - COUGHED UP BLOOD? YES / NO
- BEEN EXPOSED TO TUBERCULOSIS? YES / NO
DOES IT HURT YOU TO TAKE DEEP BREATHS? YES / NO

ABDOMEN

IS YOUR WEIGHT INCREASING? YES / NO
ARE YOU HAPPY WITH YOUR PRESENT WEIGHT? YES / NO

WHAT DO YOU THINK YOUR IDEAL WEIGHT SHOULD BE? _____

DO YOU - HAVE A GOOD APPETITE? YES / NO
- VOMIT FREQUENTLY? YES / NO
- PASS BLACK STOOLS? YES / NO

DO YOU SUFFER FROM - HEARTBURN? YES / NO
- REFLUX OF FOOD? YES / NO
- INDIGESTION? YES / NO
- CONSTIPATION? YES / NO
- DIARRHOEA? YES / NO
- STOMACH PAINS? YES / NO
- ABDOMINAL CRAMPS? YES / NO

DOES IT HURT YOU TO PASS A BOWEL MOTION? YES / NO

HAVE YOU EVER - BEEN JAUNDICED (YELLOW)? YES / NO
- HAD A HERNIA? YES / NO
- HAD AN ULCER? YES / NO
- HAD PILES/HAEMORRHOIDS? YES / NO
- HAD COLITIS? YES / NO
- VOMITED BLOOD? YES / NO
- PASSED YELLOW MUCUS IN YOUR STOOL? YES / NO

HAVE YOU RECENTLY LOST WEIGHT? YES / NO

HAVE YOU NOTICED CONSTANT ABDOMINAL BLOATING? YES / NO

GYNAECOLOGICAL

WHEN WAS YOUR LAST CERVICAL SMEAR TEST? _____

DO YOU SUFFER FROM HOT FLUSHES? YES / NO

ARE YOU WORRIED ABOUT - ANY BREAST LUMPS? YES / NO
- NIPPLE DISCHARGE? YES / NO
- YOUR PERIODS? YES / NO
- ANY VAGINAL DISCHARGE? YES / NO
- CONTRACEPTION? YES / NO

ORTHOPEDIC

DO YOU HAVE ANY - PAINS IN YOUR BONES? YES / NO
- PAINS IN YOUR BACK? YES / NO
- DEFORMED JOINTS? YES / NO
- STIFF JOINTS? YES / NO
- LIMITATION OF MOVEMENT? YES / NO

HAVE YOU HAD ANY FRACTURES? YES / NO

EAR, NOSE AND THROAT

DO YOU HAVE - POOR HEARING? YES / NO
- POOR BALANCE? YES / NO
- DIZZY SPELLS? YES / NO
- RINGING SOUNDS IN YOUR EARS? YES / NO
- DIFFICULTY BREATHING THROUGH YOUR NOSE? YES / NO
- CONSTANT RUNNY NOSE? YES / NO
- POOR SENSE OF SMELL OR TASTE? YES / NO
- DENTAL OR GUM PROBLEMS? YES / NO
- PAINS IN YOUR FACE? YES / NO
- FREQUENT SORE THROATS? YES / NO
- DIFFICULTY SWALLOWING? YES / NO

ENDOCRINE

DO YOU HAVE - TROUBLE WITH THIRST? YES / NO
- EXCESSIVE LOSS OF ENERGY? YES / NO
- CONSTANT BOUTS OF SHIVERING? YES / NO
- PERMANENT FATIGUE? YES / NO
- PROBLEMS WITH YOUR GLANDS? YES / NO
- PROBLEMS WITH EXCESSIVE SWEATING? YES / NO

SKIN

DO YOU SUFFER FROM ATHLETE'S FOOT? YES / NO
HAVE YOU HAD ANY MOLES REMOVED? YES / NO
DO YOU HAVE ANY - SKIN PROBLEMS? YES / NO
- HAIR PROBLEMS? YES / NO
ARE YOU WORRIED ABOUT - ANY MOLES? YES / NO
- ANY LUMPS? YES / NO
- ANY RASH? YES / NO
- VARICOSE VEINS? YES / NO
DO YOU SUFFER FROM - ITCHY SKIN? YES / NO
- ITCHY OR WATERY EYES? YES / NO
- DRY EYES? YES / NO