HealthCheck

Vhi Health Assessment

Questionnaire

These services are
provided and operated by
Vhi Health & Wellbeing DAC

1. Personal information

Surname: _____ Forename: _____

Address: _____

_____

Preferred contact phone number: _____ Occupation: _____

Date of birth: ☐☐☐☐☐☐

Sex: ☐ Male ☐ Female ☐ Intersex Gender: ☐ Male ☐ Female ☐ Non-Binary

General practitioner name: _____

General practitioner address: _____

_____

Next of Kin name: _____ Next of Kin contact number: _____

2. Medical history

In general, would you say your health is: ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

How would you describe your dental health? ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Please indicate by ticking yes or no, if you have been diagnosed with any of the following conditions:

High blood pressure: ☐ Yes ☐ No

Heart or Cardiovascular Condition: ☐ Yes ☐ No

Diabetes/pre-diabetes: ☐ Yes ☐ No

Any other medical condition: ☐ Yes ☐ No

If you answered Yes to any of the above questions, please explain briefly:

_____

Are you taking any regular medication: ☐ Yes ☐ No

If you answered Yes, please list **all** medications (including prescribed/over the counter/herbal supplements):

_____

_____

Do you have any allergies: ☐ Yes ☐ No

Details: _____

Other diseases that run in the family: _____

_____

3. Family History

Do any of your immediate* family suffer(ed) from:

Cancer	☐ No	☐ Yes	☐ Don't know
Heart disease	☐ No	☐ Yes	☐ Don't know
Haemochromatosis	☐ No	☐ Yes	☐ Don't know
Other diseases that run in the family	☐ No	☐ Yes	☐ Don't know

If yes please specify _____

_____

* This includes blood relatives (i.e. father, mother, brother, sister, grandparents, cousins etc) but not relatives through marriage

4. Patient Priorities:

Which one of the topics below is the most important to talk with your doctor about today?

- ☐ Medical History
- ☐ Family History
- ☐ Risk of developing diabetes
- ☐ Smoking
- ☐ Alcohol
- ☐ Substance Misuse
- ☐ Physical Activity
- ☐ Nutrition & Eating Patterns
- ☐ Medication Adherence
- ☐ Stress
- ☐ Anxiety
- ☐ Depression
- ☐ Social & Emotional Support
- ☐ Spiritual Practice
- ☐ Passion & Hobbies
- ☐ Sexual Health
- ☐ Sleep

5. Risk of Developing Diabetes

Do you eat vegetables, fruit or berries **everyday**? ☐ Yes ☐ No

Do you usually have at least 30 minutes of physical activity each day at work and/or during leisure time (including normal daily activity)? ☐ Yes ☐ No

Have you ever taken antihypertensive (blood pressure) medication regularly? ☐ Yes ☐ No

Have you ever been found to have high blood glucose (e.g. in a health examination, during an illness)? ☐ Yes ☐ No

Did you have a high glucose during pregnancy (female only)? ☐ Yes ☐ No

Have any of your immediate family or other relatives been diagnosed with diabetes (Type 1 or Type 2)? ☐ Yes ☐ No

If the answer to the above question is **Yes**, please specify the relationship category, by ticking the box next to the diagnosed relative group as below:

Group (a) grandparent, aunt, uncle or first cousin ☐ Yes ☐ No

Group (b) parent, brother, sister or own child ☐ Yes ☐ No

If yes, do you participate in the diabetic retina screening programme? ☐ Yes ☐ No

6. Smoking

Please tick the box that is applicable to you:

☐ Smoker ☐ Ex-smoker ☐ Non-smoker

Year started smoking: ☐☐☐☐ Year stopped smoking: ☐☐☐☐

Number of cigarettes: ☐ or cigars: ☐ or pipe smoked: ☐ smoked per day

If you only smoke occasionally please put down an average number e.g. 20 cigarettes once a month is less than 1 per day

Do you use e-cigarettes: ☐ No ☐ Yes

7. Alcohol & Drug Use

Do you drink alcohol: ☐ No ☐ Yes ☐ Occasionally/seldom

If you answered Yes to the above question please indicate how many of each of the following you would consume in an average week:

a. Pints of beer/cider: ☐

b. bottles of beer: ☐

c. small glasses of wine: ☐

d. Pub measure of spirits (1 short) : ☐

e. Alco-pops ☐

f. Cans of beer/cider: ☐

If you only drink occasionally please put down a weekly average e.g. 8 standard drinks once a month is the equivalent of 2 a week. Note one standard drink is a pub measure of spirits (35.5ml), a small glass of wine (12.5%vol) or half a pint of normal strength beer.

How often do you have six or more standard drinks?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Have you ever felt that you ought to cut down on your drinking? ☐ No ☐ Yes

Have you ever felt that you ought to cut down on your drinking or drug use? ☐ No ☐ Yes

8. Physical Activity

In a typical week, on how many days have you done a total of 30 minutes or more of physical activity, which was enough to raise your breathing rate?

(This may include sport, exercise and brisk walking or cycling for recreation or to get to and from places, but should not include housework or physical activity that may be part of your job)

☐ 7 ☐ 6 ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ 0

9. Nutrition and Eating Patterns

How many portions/servings of each of the following foods do you eat on average per day?

Food type * Note a portion is usually a small fist sized amount	Less than 1 portion	1 portion	2 portions	3 portions	4 portions	5 portions or greater
Vegetables, salad or fruit						
Wholemeal cereals, breads, potatoes, pasta or rice						
Milk, yoghurt or cheese						
Meat, poultry, fish, eggs, beans or nuts						
Fats, butter, spreads or oils						
Foods and drinks high in fats, sugar or salt e.g. crisps, salted nuts, cakes and biscuits						
How many times a week would you eat takeaways?						
How many glasses/cups (200ml) of water or other fluids do you drink on average per day? (including tea, coffee, milk etc)						

10. Medication Adherence

How often do you have trouble taking medicines the way you have been told to take them?

- ☐ I do not have to take medicine
- ☐ I always take them as prescribed
- ☐ Sometimes I take them as prescribed
- ☐ I seldom take them as prescribed

11. Stress

On scale of 1-10 how stressed are you?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

1 = Not stressed 10 = Extremely stressed

How often is stress a problem for you in handling such things as: Your health? Your finances? Your family or social relationships? Your work?

☐ Never or rarely

☐ Sometimes

☐ Often

☐ Always

12. Social and Emotional Support

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

13. Spiritual Practice - (For example Meditation, Yoga, Mindfulness, Prayer)

Do you have a spiritual practice?

☐ No ☐ Yes

14. Passion and Hobbies

Do you have a passion or hobby that gives you a sense of joy?

☐ No ☐ Yes

15. Sleep

Generally do you sleep well? ☐ No ☐ Yes

Do you snore or has anyone told you that you snore? ☐ No ☐ Yes

In the past 7 days, have you fallen asleep inappropriately during the daytime?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

Do you bring your phone to bed? ☐ No ☐ Yes

Do you wake from sleep to check your phone? ☐ No ☐ Yes

Do you use your phone when you're in bed? ☐ No ☐ Yes

Tick where appropriate

Do you examine your breasts regularly? ☐ No ☐ Yes

Do you have breast implants? ☐ No ☐ Yes

Have you ever had a mammogram? ☐ No ☐ Yes

If Yes, please state date performed and result: Date: ☐☐☐☐☐☐

Result: ☐

Have you ever had a cervical smear test? ☐ No ☐ Yes

If Yes, please state date performed and result: Date: ☐☐☐☐☐☐

Result: ☐

Tick where appropriate

Do you have lumps or swelling in your testicular region? ☐ No ☐ Yes

If Yes, please give details: _____

Do you examine your testicles regularly? ☐ No ☐ Yes

OFFICE USE ONLY:

FOR COMPLETION BY NURSE: (1 of 2)

Risk assessment

Is patient on anticoagulant e.g. warfarin? ☐ Yes ☐ No

If Yes, please advise of haematoma risk

Does the person understand the information provided?

Verbally ☐ Yes ☐ No

Written ☐ Yes ☐ No

Was the person in hospital (here or abroad) in last 6 months? ☐ Yes ☐ No

Does the person have any allergies? ☐ Yes ☐ No

If Yes, refer to Medical history section

Do any of the following risk factors put the person at increased risk of slips, trips and falls?

☐ Walking aids

☐ Obese

☐ Vision impaired

☐ History of unexplained falls

Record if any extra precautions taken:

Questionnaire fully completed ☐ Yes ☐ No *Please sign and date any clarifications/changes*

BP: ☐ / ☐ mmHg. *Record lowest if multiple readings.*

BP arm: Right or Left: ☐ Cuff size: ☐

Blood pressure medication: ☐ Yes ☐ No

Taken today: ☐ Yes ☐ No

Height ☐ cm Weight ☐ Kgs

Waist ☐ cm BMI ☐

Has person fasted (8 hours)? ☐ Yes ☐ No

Blood sample bottles labelled: ☐ Yes ☐ No

Venepuncture: Arm: ☐ Right ☐ Left

Consent given? ☐ Yes ☐ No

Post-Venepuncture: No complaints voiced ☐ Yes ☐ No

Comments: _____

OFFICE USE ONLY:

FOR COMPLETION BY NURSE: (2 of 2)

Final check: is the form fully completed? ☐ Yes ☐ No

Date of screen: ☐☐☐☐☐☐

Nurse's signature: _____ NMBI number: ☐

If any test is done by a different Nurse the individual entry must be signed and dated.

OFFICE USE ONLY:

FOR COMPLETION BY DOCTOR: (1 of 3)

Assessment

History: _____

Personal medical history: _____

Medications: _____

Allergies: _____

Family history: _____

Lifestyle (smoking, alcohol, diet, exercise): _____

Pain Assessment: Is patient in ongoing pain anywhere right now? ☐ Yes ☐ No

If so, where? _____

Does pain ever keep them from sleeping at night or doing activities they enjoy? ☐ Yes ☐ No

Are they in pain every day? ☐ Yes ☐ No

If yes, how would they rate the pain on a scale of 1 to 10? 1 = Very mild 10 = Extreme pain ☐

Details:

Cardiac risk assessment: _____

Cardiac history (CVD, lipids, BP): _____

Cardiac medications: ☐ Yes ☐ No

Diabetes: ☐ Yes ☐ No

FHx CVD or SCD: ☐ Yes ☐ No

Symptoms (chest pain, dyspnoea, palpitations, pre-syncope/syncope):

_____

Notes:

Heart Sounds: _____

Murmurs: _____

Chest exam: ☐ No Abnormality Identified ☐ Abnormal

Breast exam: ☐ No Abnormality Identified ☐ Abnormal

Testicular exam: ☐ No Abnormality Identified ☐ Abnormal

Comments: _____

_____

Chaperone offered? ☐ Not applicable ☐ Yes – declined ☐ Yes – accepted

If accepted please complete name of chaperone and ask them to sign form: _____

Test Results:

ECG ☐ Yes ☐ No

Cardiovascular risk factors explained? ☐ Yes ☐ No

Diabetes risk score explained? ☐ Yes ☐ No

Medical report and blood test results explained? ☐ Yes ☐ No

Follow up required:

Confirmed understanding of advice and education requirements: ☐ Yes ☐ No

Was person given literature/education material?

☐ Yes

☐ Not required

☐ Offered but declined

If Yes, please specify: _____

_____

OFFICE USE ONLY:

FOR COMPLETION BY DOCTOR: (3 of 3)

Anxiety

Over the past 2 weeks, how often has the patient felt nervous, anxious, or on edge?

☐ Not at all ☐ Several days ☐ More days than not ☐ Nearly every day

Over the past 2 weeks, how often was the patient not able to stop worrying or control their worrying?

☐ Not at all ☐ Several days ☐ More days ☐ Nearly every day

Depression

Over the past 2 weeks, how often has the patient felt down or depressed?

☐ Not at all ☐ Several days ☐ More days ☐ Nearly every day

Over the past 2 weeks, how often has the patient felt little interest or pleasure in doing every day things?

☐ Not at all ☐ Several days ☐ More days ☐ Nearly every day

Member referred to EAP ☐ Yes ☐ No

Sexual Health Discussed ☐ Yes ☐ No

Doctors Comments _____

_____

_____

_____

_____

Date: _____

Signature: _____

MRCN: _____


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