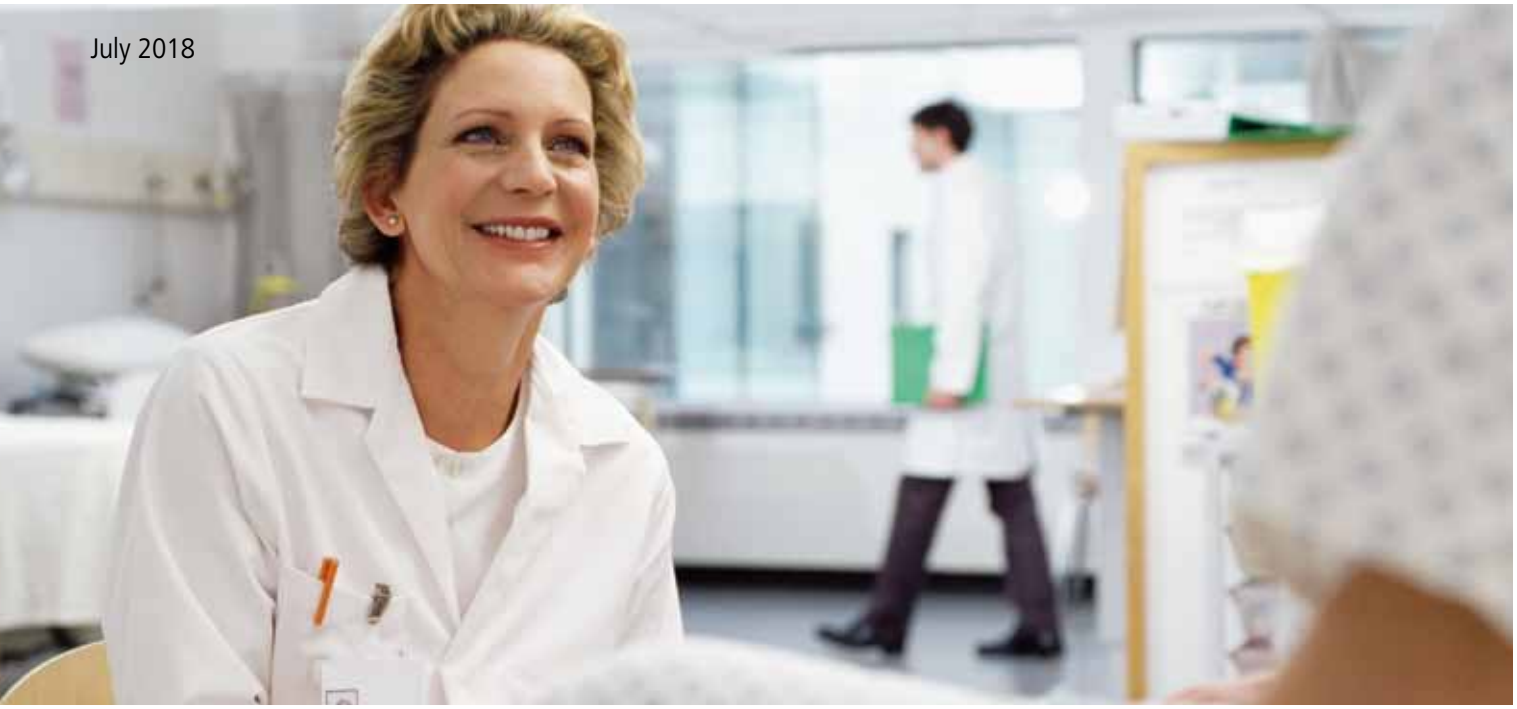
July 2018



Vhi Medical Centre

Medical Screening
Questionnaire

Please complete pages 2 to 7 before your appointment.

You will be asked to complete page 1 in Vhi Medical Centre during your appointment.

Affix identification label here

Section 1. **Consent form**

The services provided in Vhi Medical Centres assess specific important aspects of your health. They are designed to help identify factors which may cause potential health issues for you in the future, with the aim of giving you and your GP the information necessary to address these and reduce your risk of future problems.

The tests we provide have been selected to cause as little discomfort or inconvenience as possible. Taking blood tests does involve some discomfort and may cause minor bruising. Occasionally this bruising may be more severe.

Please read the enclosed Information Pack carefully as it contains:

- A description of the tests included
- Medical inclusion/exclusion criteria as some of the tests are not available to everyone and are subject to medical suitability
- Instructions to help you prepare for your appointment

Informed Consent

Please do not sign in advance.

- I have read and understand the information provided about the service in the Information Pack.
- I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- I understand that the service is not designed to evaluate established illness and results relating to prior illness may be misleading.
- I understand that the tests performed are not suitable for assessing active medical problems.
- I accept that a copy of my report will be sent to my GP and if any serious issues are identified my GP may be contacted directly.
- I also accept that if there are any abnormal results I will be advised to attend my GP and/or Consultant for further management, and I will be responsible for acting on that advice.
- I accept that Vhi may also share my data with trusted third parties who process data on its behalf (e.g. laboratory, scanning services) inside and outside of the European Economic Area. Data may also be shared with state bodies as required by law.
- I understand that any follow-up treatment with my GP and/or Consultant is not part of the service, but I may be able to submit the receipt as part of an out-patient claim subject to the terms and conditions of my chosen insurance plan.

Data Protection Notice

In order to provide the Screening service to you, Vhi Health Services will process the personal data that you have provided, together with any personal data that you have authorised third parties to provide to us. Processing of your personal data is required in order for us to provide the Screening service and for us to be able to operate the business of providing health services.

Vhi Health Services DAC of Waverly Business Park, Old Naas Road, Dublin 12 is the company that controls and is responsible for processing the personal data in Vhi Medical Centres' services. It will process your personal data in accordance with the Vhi Data Protection Statement which has previously been provided to you. If you would like another copy of the Vhi Data Protection Statement it is available at Vhi.ie, or you can request a copy by calling us on (056) 444 4444 or 1890 44 44 44.

Declaration

By signing this consent form, you explicitly consent to Vhi processing your details for the purposes described above.

I understand that in certain circumstances, I may be advised to visit my GP for further assessment and information will be disclosed to him/her. I understand that any additional follow up health treatment arising from the screening service is not included and is subject to the normal rules of my health insurance policy.

I hereby consent to the above tests being conducted, the use of personal information relating to me for the purpose described above and the disclosure of such information to the parties referred to above for that purpose.

Participant's signature: _____ Date: D D M M Y Y

Witness's signature: _____ Date: D D M M Y Y

Section 2. **Personal information**

Surname: Forename:

Address: Occupation:

Preferred contact phone number:

Gender: Male ☐ Female ☐

Date of birth: ☐☐ ☐☐ ☐☐

General practitioner name:

General practitioner address:

Next of Kin name: Next of Kin contact number:

Section 3. **Medical history**

Cardiovascular	Yes	No		Yes	No
a. High blood pressure:	☐	☐	**e.** Bypass surgery:	☐	☐
b. High cholesterol:	☐	☐	**f.** Coronary stent:	☐	☐
c. Angina:	☐	☐	**g.** Peripheral vascular disease:	☐	☐
d. Heart attack:	☐	☐			

Please indicate if you have been diagnosed with any of the following conditions:

Respiratory	Yes	No	**Nervous system**	Yes	No
a. Asthma:	☐	☐	**a.** Stroke/TIA (mini-stroke):	☐	☐
b. COPD/emphysema:	☐	☐			

General	Yes	No		Yes	No
a. Thyroid disease:	☐	☐	**e.** Cancer:	☐	☐
b. Liver disease:	☐	☐	**f.** Eye disease:	☐	☐
c. Diabetes:	☐	☐	**g.** Visual impairment (not including long/short sight requiring glasses):	☐	☐
d. Anaemia/blood disorders:	☐	☐			

Continued overleaf

Affix identification label here

Continued from Page 2

Hearing	Yes	No		Yes	No
a. Do you wear a hearing aid?	☐	☐	**c.** Do you have ear trouble (e.g. wax or infections)?	☐	☐
b. Do you have any hearing impairment?	☐	☐	**d.** Have you had a previous hearing test?	☐	☐

Gastrointestinal	Yes	No	**Renal**	Yes	No
a. Peptic ulcer disease:	☐	☐	**a.** Chronic kidney disease:	☐	☐
b. Crohn's/ulcerative colitis:	☐	☐	**b.** Kidney stones:	☐	☐
c. Irritable bowel syndrome:	☐	☐	**c.** Recurrent kidney/ bladder infection:	☐	☐

Have you had a previous colonoscopy? Yes ☐ No ☐

If Yes, please state date performed and result:

Other medical conditions or issues not listed (please specify):

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

Please give details of any surgical procedures:

Do you take any **medications**? Yes ☐ No ☐

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

Do you have **allergies** to: Latex ☐ Plasters ☐ Other (including medications) ☐

Details:

Pain: Are you in pain anywhere right now? Yes ☐ No ☐ If so, where?

Can pain ever keep you from sleeping at night, or keep you from participating in activities you enjoy? Yes ☐ No ☐

Are you in pain every day? Yes ☐ No ☐

What would you rate your pain on a scale of 1-10? ☐ *1 = Very mild 10 = Extreme pain*

Details:

Section 4. **Family history**

Do you know if any of your immediate* family suffer(ed) from:
* This includes blood relatives (i.e. father, mother, brother, sister, grandparents, cousins etc) but not relatives through marriage.

	Yes	No	Don't know	**Relationship** (Father, mother, brother, sister etc)	**Age** at which they presented with the condition
a. High cholesterol:	☐	☐	☐		
b. High blood pressure:	☐	☐	☐		
c. Angina:	☐	☐	☐		
d. Heart attack:	☐	☐	☐		
e. Stroke/TIA (mini-stroke):	☐	☐	☐		
f. Asthma/COPD:	☐	☐	☐		
g. Haemachromatosis:	☐	☐	☐		
h. Cancer related diseases:	☐	☐	☐		

i. Other conditions (please specify):

_____

_____

Section 5. **Risk of developing diabetes**

	Yes	No
Do you eat vegetables, fruit or berries **everyday**?	☐	☐
Do you usually have at least 30 minutes of physical activity each day at work and/or during leisure time (including normal daily activity)?	☐	☐
Have you ever taken antihypertensive (blood pressure) medication regularly?	☐	☐
Have you ever been found to have high blood glucose (e.g. in a health examination, during an illness)?	☐	☐
Did you have a high glucose during pregnancy (female only)?	☐	☐
Have any of your immediate family or other relatives been diagnosed with diabetes (Type 1 or Type 2)?	☐	☐
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	☐	☐
Group (b) parent, brother, sister or own child	☐	☐

Affix identification label here

Section 6. **Social history**

Smoking

Please tick the box that is applicable to you:

a. Smoker ☐ **b.** Ex-smoker ☐ **c.** Non-smoker ☐

d. Year started smoking: ☐☐☐☐ **e.** Year stopped smoking: ☐☐☐☐

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

g. E-cigarettes: Which of the following statements best applies to you?

I have never heard of e-cigarettes and I have never tried them ☐

I have heard of e-cigarettes but I have never tried them ☐

I have tried e-cigarettes but I do not use them anymore ☐

I have tried e-cigarettes and still use them on a daily basis ☐

I have tried e-cigarettes and still use them less than daily ☐

Don't know ☐

Alcohol intake and drug use

Do you drink alcohol: Yes ☐ No ☐ 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.** Glasses of wine: ☐☐

d. Measure of spirits (1 short): ☐☐ **e.** Alco-pops: ☐☐ **f.** Cans of beer/cider: ☐☐

How many days of the week do you have six or more standard drinks?

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

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

Drug use (including illegals drug use and the use of prescription drugs other than as prescribed:

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

Have people annoyed you by criticising your drinking or drug use? Yes ☐ No ☐

Have you ever felt bad or guilty about your drinking or drug use? Yes ☐ No ☐

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover? Yes ☐ No ☐

Continued overleaf

Physical activity/exercise

Tick the appropriate box

How often do you exercise for 30 minutes or more* outside of your normal work or daily responsibilities?	**a.** Seldom/never	☐
	b. Less than once a week	☐
	c. 1-2 days a week	☐
	d. 3-4 days a week	☐
	e. 5-6 days a week	☐
	f. Daily	☐
If you are currently working, how much hard physical work is required on your job?	**a.** Great deal	☐
	b. Moderate amount	☐
	c. Little	☐
	d. None	☐

* Note: this would be exercise that moderately increases your breathing and heart rate, and makes you sweat (such as brisk walking, cycling, swimming, jogging, aerobics or climbing stairs).

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

Over the last 2 weeks how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed or hopeless	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐

Dietary information

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

Food type ** Note a portion is usually a small fist sized amount*	Less than every day	Very small amounts	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, spreads or oils	☐	☐	☐	☐	☐	☐	☐
Foods and drinks high in fats, sugar or salt	☐	☐	☐	☐	☐	☐	☐

How many glasses/cups (200ml) of water or other fluids do you drink on average per day? ☐☐

Affix identification label here

Section 7. **For female participants**

	Yes	No
Do you still menstruate?	☐	☐
Have you ever been pregnant? If Yes, please state number of pregnancies: ☐☐	☐	☐
Do you examine your breasts regularly?	☐	☐
Do you have breast implants?	☐	☐
Have you ever had a mammogram? If Yes, please state date performed and result: Date: ☐☐☐☐☐☐ Result:	☐	☐
Have you ever had a cervical smear test? If Yes, please state date performed and result: Date: ☐☐☐☐☐☐ Result:	☐	☐

Section 8. **For male participants**

	Yes	No
Do you have lumps or swelling in your testicular region? If Yes, please give details: _____ _____	☐	☐
Do you examine your testicles regularly?	☐	☐
Have you ever had a prostate screening test? If Yes, please state date performed and result: Date: ☐☐☐☐☐☐ Result:	☐	☐

Section 9. **OFFICE USE ONLY:**

Affix identification label here

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 person understand information? Verbally Yes ☐ No ☐ Written Yes ☐ No ☐

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

Does person have any allergies? Yes ☐ No ☐ *If Yes, refer to Medical history section*

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

Walking aids	Yes ☐	No ☐	Vision impaired	Yes ☐	No ☐
Obese	Yes ☐	No ☐	History of unexplained falls	Yes ☐	No ☐
Elderly (unassisted)	Yes ☐	No ☐			

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

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 ☐

Comments:

FOR COMPLETION BY NURSE: (2 of 2)

Lung function

Results attached: Yes ☐ No ☐ N/A ☐ Number of attempts: ☐

Medical criteria questions asked? Yes ☐ No ☐ Criteria met: Yes ☐ No ☐

Position: Standing ☐ Sitting ☐

Comments:

Vision test

Results attached: Yes ☐ No ☐ N/A ☐

Comments:

ECG

Results attached: Yes ☐ No ☐ N/A ☐

Comments:

Colon cancer screening: (Extra Only)

Is person eligible for colon screening? Yes ☐ No ☐

= Aged 50 - 74
= No history of colon cancer, inflammatory bowel disease, crohn's disease, ulcerative colitis
= No history or family history of polyposis coli or hereditary non polyposis coli

Given sample pack Yes ☐ No ☐

Explained sample pack Yes ☐ No ☐

Comments:

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

Nurse's signature: NMBI number: Time:

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

Section 10. **OFFICE USE ONLY:**

Affix identification label here

FOR COMPLETION BY DOCTOR: (1 of 3)

Audiometry

Does person have any difficulty with hearing?	Yes ☐	No ☐
Have they noticed any change in hearing in the last 6 months?	Yes ☐	No ☐
Have they ever had a hearing test before and if so, what was the result?	Yes ☐	No ☐
Do they use a hearing aid?	Yes ☐	No ☐
Have they had a cold or an ear infection in the last fortnight?	Yes ☐	No ☐
Have they had ear problems in the past (infections, wax, glue ear)?	Yes ☐	No ☐
Do they have any pain or discharge in the ear?	Yes ☐	No ☐
Have they been exposed to loud noise in the last 24 hours e.g. at disco/pub/working with power tools or in a noisy area?	Yes ☐	No ☐
Have they a history of significant loud noise exposure in the past (e.g. occupational)?	Yes ☐	No ☐
Do they suffer with tinnitus or vertigo?	Yes ☐	No ☐
Ear examination completed?	Yes ☐	No ☐

✓ = Pass X = Fail	Left ear				Right ear			
	500Hz/30dB	1000Hz/25dB	2000Hz/25dB	4000Hz/25dB	500Hz/30dB	1000Hz/25dB	2000Hz/25dB	4000Hz/25dB
Test								
Repeat test								

Result: **Left ear** Pass ☐ Fail ☐ **Right ear** Pass ☐ Fail ☐

Comments:

PSA/DRE (Screen Extra only)

Eligible for PSA/DRE testing?	Yes ☐	No ☐	PSA requested on sample lab request form?	Yes ☐
Taking prostate medication?	Yes ☐	No ☐	Previous abnormal PSA?	Yes ☐ No ☐
Discussed with person?	Yes ☐	No ☐	If Yes, Date of Test:	☐☐ ☐☐ ☐☐
Do they want test?	Yes ☐	No ☐	PSA test explained?	Yes ☐ No ☐

FOR COMPLETION BY DOCTOR: (2 of 3)

ASSESSMENT

History:

Personal medical history:

Medications:

Allergies:

Family history:

Lifestyle (smoking, alcohol, diet, exercise):

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):

Examination:

BP:

BMI:

Pulse:

Heart sounds:

Murmurs:

Chest exam: Normal ☐ Abnormal ☐

Ear exam: Normal ☐ Abnormal ☐

Breast exam: Normal ☐ Abnormal ☐

Testicular exam: Normal ☐ Abnormal ☐

Continued overleaf

Section 10. **OFFICE USE ONLY:**

Affix identification label here

FOR COMPLETION BY DOCTOR: (3 of 3)

DRE: Normal ☐ Abnormal ☐

Other:

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

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

Test Results:

ECG:

Spirometry:

Audiometry:

Cardiac risk score explained? Yes ☐

Diabetes risk score explained? Yes ☐

Medical report and blood test results explained? Yes ☐

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:

Date: ☐☐☐☐☐☐ Signature: MRCN: