

July 2018



Vhi Medical Centre

Heart and Cancer Risk Questionnaire

Please complete pages 2 to 6 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
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Witness's signature: _____ Date:

D	D	M	M	Y	Y
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Section 2. Personal information

Surname:

Forename:

Address:

Occupation:

Preferred contact phone number:

Date of birth:

Gender: Male Female

Race/ethnicity: African Asian

General practitioner name:

Caucasian (white) Other

General practitioner address:

Next of Kin name:

Next of Kin contact number:

Section 3. Medical history

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

- | | | | | | |
|--------------------------------|------------------------------|-----------------------------|---------------------------------|------------------------------|-----------------------------|
| a. COPD/emphysema: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | i. Bypass surgery or stent: | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b. Cancer: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | j. Kidney disease: | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c. Crohn's/ulcerative colitis: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | k. Liver disease: | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d. High blood pressure: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | l. Thyroid disease: | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| e. High cholesterol: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | m. Diabetes/pre-diabetes: | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| f. Angina: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | n. Peripheral vascular disease: | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| g. Heart attack: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | o. Aortic aneurysm: | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| h. Stroke/TIA (mini-stroke): | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | |

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

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

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

Please give details of any cancer related conditions in your family.

	Diagnosis	Age at diagnosis	If deceased, what was their age at death?
Mother			
Father			
Brother			
Sister			
Child			
Other relative			

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

* This includes blood relatives (i.e. father, mother, grandparents, sister, brother, 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:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
b. High blood pressure:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
c. Angina:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
d. Heart attack:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
e. Stroke/TIA (mini-stroke):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
f. Diabetes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
g. Other conditions (please specify):				_____	_____

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Section 5. 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 illegal 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Dietary information

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

Food type	Less than every day	Very small amounts	1 portion	2 portions	3 portions	4 portions	5 portions or greater
Vegetables, salad or fruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wholemeal cereals, breads, potatoes, pasta or rice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Milk, yoghurt or cheese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meat, poultry, fish, eggs, beans or nuts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fats, spreads or oils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foods and drinks high in fats, sugar or salt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

<input type="text"/>	<input type="text"/>
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Section 6. For female participants

	Yes	No
Do you still menstruate?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, please state number of pregnancies: <input type="text"/> <input type="text"/>		
Do you examine your breasts regularly?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have breast implants?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a mammogram?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, please state date performed and result:		
Date: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Result:		
Have you ever had a cervical smear test?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, please state date performed and result:		
Date: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Result:		

Section 7. For male participants

	Yes	No
Do you have lumps or swelling in your testicular region?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, please give details:		
Do you examine your testicles regularly?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a prostate screening test?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, please state date performed and result:		
Date: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Result:		

Section 8. OFFICE USE ONLY:

FOR COMPLETION BY NURSE:

Risk assessment: Is person on an anticoagulant e.g. warfarin Yes No

If Yes, please advise of haematoma risk: _____

Does person understand information: Verbally Yes No Written Yes No

Does person have any allergies? Yes No (if Yes, refer to Medical history section)

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

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

Walking aids	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Vision impaired	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Obese	Yes <input type="checkbox"/>	No <input type="checkbox"/>	History of unexplained falls	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Elderly (unassisted)	Yes <input type="checkbox"/>	No <input type="checkbox"/>			

Record if any extra precautions taken:

BP: / mmHg. Record lowest if multiple readings. BP arm: Right or Left Cuff size:

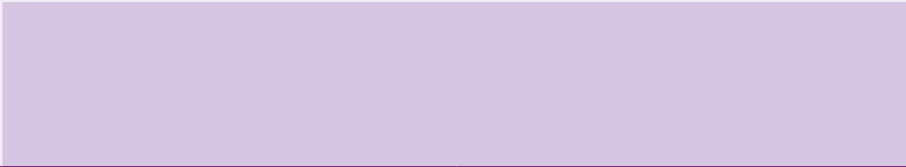
Blood pressure medication: Yes No Taken today: Yes No

Record if advice given in relation to blood pressure:

Height . cm Weight . Kgs Waist . cm

Pacemaker? Yes No Body fat % measured? Yes No

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Blood samples

Has the member fasted? Yes No

Blood samples labelled? Yes No

Post-Venepuncture:
No complaints voiced:

Venepuncture

Arm

Consent given?

Right Left

Yes No

ECG Results attached Yes No N/A

Colon Cancer Screening

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

Multiple horizontal lines for entering comments.

Final check: is the form fully completed? Yes No Date: Time:

Nurse's signature: _____ NMBI number: _____ Time: _____

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

Section 9. OFFICE USE ONLY:

FOR COMPLETION BY DOCTOR: (1 of 2)

PSA/DRE

Eligible for PSA/DRE testing?

Yes No

Taking prostate medication?

Yes No

Discussed with person?

Yes No

Do they want test?

Yes No

PSA requested on sample lab request form?

Yes N/A

Previous Abnormal PSA?

Yes No

If Yes, Date of Test:

Chaperone offered

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

Not applicable

Yes - declined

Yes - accepted

Chaperone signature:

Assessment:

History:

Personal medical history:

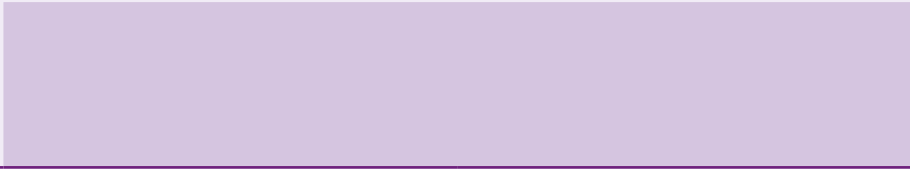
Medications:

Allergies:

Family history:

Lifestyle (smoking, alcohol, diet, exercise):

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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):

ECG reviewed? Yes No

Test results and discussion:

Examination and self-examination advice/education:

Follow up required / advised:

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:

