

July 2018



Vhi Medical Centre

HeartCheck Questionnaire

Please complete pages 2 to 5 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:

Witness's signature: _____

Date:

Section 2. Personal information

Surname:

Forename:

Address:

Occupation:

Preferred contact phone number:

Date of birth:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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General practitioner name:

General practitioner address:

Next of Kin name:

Next of Kin contact number:

Gender: Male Female Race/ethnicity: African Asian Caucasian (white) Other

Section 3. Medical problems *Please indicate if you have any of the following conditions:*

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

m. Other medical conditions or issues (please specify):

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

o. 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 painDetails:

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Section 4. Family history

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):

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 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

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).

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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" value=""/> <input type="text" value=""/>

Section 6. OFFICE USE ONLY:**Affix identification label here****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 No Vision impaired Yes No Obese Yes No History of unexplained falls Yes No Elderly (unassisted) Yes No

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 . cmPacemaker? Yes No Body fat % measured? Yes No **Blood samples**Has the member fasted? Yes No Blood samples labelled? Yes No **Venepuncture**Arm Right Left Consent given? Yes No

Post-Venepuncture;

No complaints voiced: ECG Results attached Yes No N/A **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 7. OFFICE USE ONLY:

FOR COMPLETION BY DOCTOR: (1 of 2)

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):

Section 7. OFFICE USE ONLY (continued):

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FOR COMPLETION BY DOCTOR: (2 of 2)

ECG reviewed? Yes No

Comment:

Test result and discussion:

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:
