## Checkup

**Medical questionnaire** (you answers will be treated in the strictest confidence)

Surname First name(s)

Address City

Date of birth Civilian status

Profession Company

Height (cm) Weight (kg)

| **Symptoms** | **yes** | **no** | **additional details (who / what / when)** |
| --- | --- | --- | --- |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. | **Did any of your relatives suffer from any of the following illnesses before the age of 65?** |  |  | (e.g. mother stomach cancer, fifty years old) |
|  | * cardiovascular diseases
 | [ ]  | [ ]  |  |
|  | * diabetes
 | [ ]  | [ ]  |  |
|  | * cancer
 | [ ]  | [ ]  |  |
|  | * diseases of the alimentary canal
 | [ ]  | [ ]  |  |
|  | * allergies
 | [ ]  | [ ]  |  |
|  | * high blood pressure
 | [ ]  | [ ]  |  |
|  | * epilepsy
 | [ ]  | [ ]  |  |
|  | * mental aberrations
 | [ ]  | [ ]  |  |
|  | * kidney diseases
 | [ ]  | [ ]  |  |
|  | * other
 | [ ]  | [ ]  |  |
|  |  |  |  |
| 2. | **Are you currently suffering fromill-health?** | [ ]  | [ ]  |  |
|  |  |  |  |  |
| 3. | **Have you ever had an operation?** | [ ]  | [ ]  |  |
| **Symptoms** | **yes** | **no** | **additional details (who / what / when)** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 4. | **Have you ever been hospitalised other than for the above operations?** | [ ]  | [ ]  | **when** |
| **reason** (e.g. pneumonia) |
|  |  |  |  |  |
| 5. | **Have you been abroad in the last few years?** | [ ]  | [ ]  | **where** |
| **for how long** |
|  |  |  |  |  |
| 6. | **Are you suffering or have you ever suffered from the following?** |  |  |  |
|  | * diseases of the circulatory organs
 | [ ]  | [ ]  |  |
|  | * diseases of the respiratory organs
 | [ ]  | [ ]  |  |
|  | * infectious diseases, notably
 | [ ]  | [ ]  |  |
|  | * tuberculosis
 | [ ]  | [ ]  |  |
|  | * venereal diseases (syphillis, gonorrhoea)
 | [ ]  | [ ]  |  |
|  | * HIV (Aids), hepatitis
 | [ ]  | [ ]  |  |
|  | * diseases of the digestive organs
 | [ ]  | [ ]  |  |
|  | * ear disorders
 | [ ]  | [ ]  |  |
|  | * eye disorders
 | [ ]  | [ ]  |  |
|  | * diseases of the motor apparatus or spinal disorders
 | [ ]  | [ ]  |  |
|  | * recurrent headaches
 | [ ]  | [ ]  |  |

| **Symptoms** | **yes** | **no** | **additional details (who / what / when)** |
| --- | --- | --- | --- |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 7.  | **Allergies?** |  |  |  |
|  | * to pollen / grasses
 | [ ]  | [ ]  |  |
|  | * to drugs
 | [ ]  | [ ]  |  |
|  | * to food
 | [ ]  | [ ]  |  |
|  | * other
 | [ ]  | [ ]  |  |
|  | **eating disorders?** | [ ]  | [ ]  |  |
|  | **depression?** | [ ]  | [ ]  |  |
|  | **‘burn-out’-syndrome?** | [ ]  | [ ]  |  |
|  | **other physical disorders?** | [ ]  | [ ]  |  |
|  |  |  |  |  |
| 8. | **Do you take at least 30 minutes exercise of medium intensity (rapid walking) per day?** | [ ]  | [ ]  | (e.g. jogging, 3 x weekly) |
|  |  |  |  |  |
| 9. | **Do you drink alcohol?** | [ ]  | [ ]  | **what kind / how much per day (d) or per week (w)**(e.g. 3 glasses of wine, 2 cl of whisky) |
|  |  |  |  |  |
| 10. | **Do you smoke?** | [ ]  | [ ]  | **number per day (d) or per week (w)**(averaged over the past year) |
| How long have you smoked? since  |  |  | cigarettes  |  |
|  |  | cigars  |  |
|  |  |  | pipe |  |
|  |  |  |  |  |
| 11. | **Please list all the medicinal drugs you have taken regularly in the past 12 months.** | **dosage** | **name** |
|  |  |
|  |  |
|  |  |
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|  |  |  |  |