The Avenue Family Practice

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MEDICAL SCREENING QUESTIONNAIRE

NAME: ____

DATE OF BIRTH: ____

PHONE NUMBER (MOBILE): ____

ADDRESS: ____

____

REGISTERED GP: ____

PRIVATE AND CONFIDENTIAL INFORMATION.

MEDICAL BACKGROUND

DO YOU HAVE ANY UNDERLYING MEDICAL CONDITIONS? Eg. ASTHMA, DIABETES,

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DO YOU TAKE ANY REGULAR MEDICATIONS?

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DO YOU ATTEND ANY MEDICAL SPECIALISTS / HOSPITAL CONSULTANTS?

____

____

DO YOU SMOKE? IF SO HOW MANY PER DAY?

____

DO YOU DRINK ALCOHOL? HOW MANY UNITS PER WEEK?

(1 PINT / GLASS OF WINE / STRONG SPIRIT = 2 UNITS)

____

IS THERE ANY FAMILY HISTORY OF SERIOUS ILLNESS? EG: HEART DISEASE / STROKE?

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____

PLEASE PLACE A TICK OPPOSITE ANY OF THE FOLLOWING SYMPTOMS THAT APPLY TO YOU.

1. SHORTNESS OF BREATH
2. COUGH
3. WHEEZE ON EXERCISE / NIGHT.
4. COUGHING UP BLOOD / SPUTUM.

GASTROINTESTINAL Q'S.

1. DIFFICULTY SWALLOWING FOOD.
2. WEIGHT LOSS
3. VOMITING
4. ABDOMINAL PAINS
5. DIARRHOEA
6. CONSTIPATION
7. BLOOD / MUCOUS IN BOWEL MOVEMENT

GENITOURINARY Q'S.

1. DIFFICULTY PASSING URINE
2. BLOOD IN URINE
3. PAIN OR STINGING WHEN PASSING URINE
4. PASSING URINE MORE FREQUENTLY THAN IN THE PAST
5. WAKING DURING THE NIGHT TO PASS URINE

CARDIOVASCULAR Q'S.

1. SHORTNESS OF BREATH ON EXERCISE
2. PAINS IN YOUR CHEST ON EXERCISE
3. PALPITATIONS OR AWARENESS OF YOUR HEART BEATING
4. SWELLING OF YOUR ANKLES
5. DIFFICULTY BREATHING AT NIGHT IN BED.

RHEUMATOLOGY / JOINT Q'S.

1. PAINFUL JOINTS
2. SWELLING OF JOINTS
3. STIFFNESS IN YOUR JOINTS IN THE MORNING
4. FATIQUE

DERMATOLOGY Q'S.

1. SKIN RASHES OR LUMPS
2. ITCH UNDER YOUR SKIN
3. CHANGE IN SIZE OR SHAPE OR COLOUR OF ANY MOLES

GYNAECOLOGY Q'S

1. HEAVY OR IRREGULAR PERIODS
2. BLEEDING IN BETWEEN MENSES
3. BLEEDING POST MENOPAUSE

NEUROLOGICAL Q'S.

1. COLLAPSE OR BLACKOUTS
2. DIZZINESS
3. HEADACHES
4. DIFFICULTY MOVING ARMS / LEGS
5. LOSS OF VISION IN ONE EYE
6. NUMBNESS OR PINS AND NEEDLES IN ARMS / LEGS
7. BALANCE PROBLEMS

MENTAL HEALTH Q'S.

1. LOW MOOD
2. POOR SLEEP / DIFFICULTY SLEEPING
3. LOSS OF APPETITE
4. ANXIETY

ARE THERE ANY OTHER ISSUES WHICH YOU WOULD LIKE TO DISCUSS IN CONFIDENCE WITH THE DOCTOR ?

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SIGNED : __________________________________ DATE : ______________________________