# Health Questionnaire
# Entry Inspection

## Basic information:

Health insurance Company: ……..
Name and surname, title: ……
Address: ……
Telephone (land line): ……..
Mobile phone: ……..
Email: ……..
Birth Reg. No.: ……..
Occupation / current employer: …….
Last preventive inspection (date, where): ……
Name and address of general practitioner, where the patient has been registered:
……..……
……

## 1) Family history:

Where there the following diseases in the blood relatives (grandparents, parents, siblings, children). If yes, please write the relation to the particular person and age onset.

| | |
|---|---|
| TB | Diabetes |
| Malignant disease | High blood pressure |
| Vascular disorder (myocardial infarction, brain stroke) | |
| Asthma | Deep vein thrombosis |
| Thyroid gland disorder | Hereditary and congenital disease |

## 2) Personal history:

Have you experienced any of the below mentioned diseases? If yes, please circle, or highlight in bold.

**Infectious Diseases:** TB, syphilis, gonorrhoea, viral hepatitis, salmonellosis, infectious mononucleosis, diphtheria, rubella, pertussis, scarlatina, other:
**Orthopaedics:** disorder of posture – scoliosis, recurrent blocks of the spine, disorder of movements in the spine or joints, other:
**Heart and blood vessel diseases:** myocardial infarction, myocardial inflammation, rheumatic fever, disorder of heart rhythm, heart insufficiency, congenital heart disorders, acquired heart disorders, atherosclerosis, other:
**Pulmonary:** asthma, chronic bronchitis, emphysema, frequent viruses, recurrent tonsillitis, other:
**Neurology:** cerebrovascular accident, disorder of sensations, sensitivity disorder, motor disorder, disorder of balance, convulsive disorder: Epilepsy, migraine, other:
**Mental disorders:** depression, mania, psychoses, alcohol dependence, toxicomania, other:

**Disorder of gastrointestinal system:** esophageal reflux, stomach and duodenal ulcer, inflammatory disorder of the bowels, recurrent constipation or diarrhoea, other:
**Disorders of the liver and gall bladder:** gall bladder inflammation, recurrent colics, gall stones, liver disease – steatosis, cirrhosis, other:
**Disorders of the pancreas:** acute or chronic pancreatitis, other:
**Kidney disorder:** repeated inflammation, colic, reduced function of the kidneys, solitary kidney, other:
**Disorder of urinary system:** repeated inflammation, urinary stones, other:
**Skin disorders:** eczema, psoriasis, inflammatory or fungi skin disorder, other:
**Eye disorders:** deteriorated vision, cataract, glaucoma, inflammations, other:
**Ear disorders:** impaired hearing, chronic inflammation of the middle ear, tinnitus, other:
**Endocrinology:** thyroid gland disorders, disorders of fat levels, gout, other:
**High blood pressure:**
**Diabetes:**
**Genitourinary disorders (in males):**

Only in women:
Gynaecological diseases: ……
Number of pregnancies, labours, possibly miscarriages:
……
Do you use any contraception? Which and for how long?
……
Last preventive check up at a gynaecologist: ……

**3) Allergic reaction:**
Enter below allergic stimuli and describe their symptoms (e.g. hay fever, conjunctivitis, skin symptoms, respiratory symptoms, etc.).
- to medication – enter the names:……
- to plaster
- to iodine
- hay, grass, pollens
- ticks, dust, fur
- food
- other:……..

**4) Other information:**

Are you followed by any of the specialised clinics? If yes give details.
……

Were you ever hospitalised? If yes, state the date and reason.

Have you ever had a surgery? If yes, state the date and reason.

Have you ever suffered a severe injury? If yes, state the date and what injury.

Do you smoke or have you smoked cigarettes or other tobacco products? If yes, provide the quantity per day and for how long.

Do you drink alcoholic drinks? If yes, provide the quantity per week and for how long.
Do you take any narcotic substances? If yes, provide the quantity and for how long.

Do you drive? If so, what group of vehicles?

Do you currently use any medication? If yes, provide a list including the dose.

Do you have up-to-date vaccination against tetanus? If yes, provide the year of the last vaccination.

What other vaccinations have you had? Enter from the vaccination card or bring it with you.

In what vaccination are you interested? E.g. seasonal flu, tick encephalitis, virus hepatitis A and B, other:

Were you ever partially or completely on disability pension?

Did you have your ability to work changed or diagnosed occupational disorder?

Other facts, which you would like to tell your doctor (you may also tell this to the doctor at the inspection personally):

…….

Date …….  Signature……..…….