Medical Questionnaire

Surname ..... **First Name(s)** .....

Date of Birth ..... **Age** .....

Address ....

..... **Phone (H)** ..... **(W)** .....

Company ..... **Position**.....

Family Doctor ....

Family History – please enter details with relevant ages

	Father	Mother	Siblings	Grandparents
Heart attacks (age)				
High blood pressure				
High cholesterol				
Diabetes (age)				
Strokes (age)				
Cancer (type/age)				
Mental illness				
Other				

Personal History – please give details with relevant dates

Major illnesses..... .....

.....

Major injuries.....

.....

Operations.....

.....

Regular medication .....

Allergies .....

Do you smoke? Yes / No Have you ever smoked? Yes / No When did you give up?.....

How many per day? ..... **How many years?** .....

Specific Medical History

Do you have any chest pains?	Yes/No
Palpitations or irregular heart beat?	Yes/No
Shortness of breath?	Yes/No
Stomach pains or indigestion?	Yes/No
Change in bowel habit?	Yes/No
Recurrent headaches?	Yes/No
Depression or low mood?	Yes/No
Moles or skin lesions of concern?	Yes/No
Have you had a colonoscopy recently?	Yes/No
Do you have any other concerns?	Yes/No

If you ticked yes to any of the questions above please provide details and dates:

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Men

Do you have a poor urinary stream, dribbling or urgency?	Yes/No
Do you have erectile problems?	Yes/No
Do you examine your testicles regularly?	Yes/No
Have you had a prostate examination recently (date)?	Yes/No

Women

Do you have regular periods?	Yes/No
Do you examine your breasts regularly?	Yes/No
Have you had a mammogram (date)?	Yes/No
Have you had a smear recently (date)?	Yes/No
Have you ever had a bone density scan (date)?	Yes/No

Exercise – please tick the most relevant box

	<2x30 min/week	3x30min	4x30 min	>4x30min
Aerobic eg running/ swimming/ walking				
Pilates/ yoga/ stretching				
Weights				
Sports eg golf/ tennis				

Social History

Are you (circle relevant): single have a partner married separated ?

Do you have any children? Yes/No

If yes how many children and what age(s)? ….....

Stress Questionnaire – please tick the most relevant box

Symptom	Rarely	Sometimes	Often	Very often	All the time
Inability to get to sleep or restless sleep					
Waking early/ can't get back to sleep					
Waking up tired and feeling fatigued all day					
Decreased energy					
Poor concentration					
Irritability or grumpiness					
Decreased interest in hobbies/sports					
Little pleasure from daily activities					
Depression, low mood, or feeling sad					
Sex drive decreased from your normal					
Feelings of anxiety or worry					
Significant change in appetite					
Lump in throat or difficulty swallowing					
Indigestion/ reflux/ stomach ulcers					
Feeling keyed up or on edge					
Headaches or migraine					
Bouts of diarrhoea or constipation					
High blood pressure, pounding, irregular or racing heart					
Chest pains					
Muscle tension					
Looking 'grey' or 'washed out'					
Working 6-7 days to keep up with work					
Work related travel (domestic/international)					
Too busy for recreation and family time					

Nutrition – please circle the answer that best reflects your dietary habits

Fruit	>4 serves per day	1-3 serves per day	<1 serve per day
Vegetables	>4 serves per day	1-3 serves per day	<1 serve per day
Nuts or seeds	>4 times per week	2-3 times per week	< once per week
Poultry	>4 serves per week	3-4 serves per week	<3 serves per week
Red meat	<3 serves per week	3-5 serves per week	>5 serves per week
Fresh fish	>4 serves per week	2-4 serves per week	<2 serves per week
Full fat cheese	<3 times per week	3-5 times per week	>5 times per week
Full fat milk	Nil	Rarely	Regularly
Eggs	<4 per week	4-5 per week	>5 per week
Butter	Nil	Rarely	Regularly
Olive oil based spreads	Every day	Most days	Rarely
Cakes/sweets/milk chocolate/ biscuits	Nil or rarely	1-2 per week	>2 per week
Crisps/chips	Nil or rarely	1-2 per week	>2 per week
Fresh fruit juice	Every day	Most days	Rarely
Soft drinks/fizzy drinks	Nil or rarely	Most days	Daily
Water	6-8 glasses daily	3-5 glasses daily	<3 glasses daily
Coffee	0-2 cups daily	3-5 cups daily	>5 cups daily
Tea	0-2 cups daily	3-5 cups daily	>5 cups daily
Alcohol	1 unit per day	2-3 units per day	<1 or >4 daily
Alcohol-free days	>3 times per week	1-2 times per week	Nil
Breakfast	Every day	Most days	<3 days per week
Fast foods or ready-made meals	Nil or rarely	1-2 times per week	>3 times per week
Restaurant,catered or buffet dining	Nil or rarely	1-2 times per week	>3 times per week
Salt	Nil	Salt while cooking	Salt at the table

What is your typical breakfast?	
Morning tea	
Lunch	
Afternoon tea	
Evening meal	
Supper	

I consent to this medical assessment, blood tests and exercise test. I understand that every effort is made to identify existing problems and promote my future good health and that Well for Life Ltd and its clinical staff cannot be held responsible for any illness discovered following this assessment. I understand that the information held by Well for Life Ltd is strictly confidential, remains my property and will not be shared without my permission.

Signed: **Date:**