

# EUROMEDICAL TOURS

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Date:

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Patient ID:

Hospital Code:

City:

## MEDICAL HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.):

M  F

DOB:

Marital status:

Single  Partnered  Married  Separated  Divorced  Widowed

Height

Weight

Previous or referring doctor:

Date of last physical exam:

### PERSONAL MEDICAL HISTORY

Childhood illness:

Measles  Mumps  Rubella  Chickenpox  Rheumatic Fever  Polio

Immunizations and dates:

Tetanus

Pneumonia

Hepatitis

Chickenpox

Influenza

MMR *Measles, Mumps, Rubella*

### LIST THE MEDICAL PROBLEM(S) THAT HAVE BEEN DIAGNOSED ALONG WITH THE RECOMMENDED TREATMENT

### Surgeries

Year

Reason

Hospital

### Other hospitalizations or medical conditions like asthma, seizures, epilepsy, fainting, diabetes, hypertension, etc

Year

Reason

Hospital

Have you ever had a blood transfusion?

Yes  No

Please turn to next page

**List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers**

Name the Drug	Strength (mg)	Frequency Taken

**Allergies to medications**

Name the Drug	Reaction You Had

**HEALTH HABITS AND PERSONAL SAFETY**

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise)				
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
<b>Diet</b>	Are you dieting?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Number of meals you eat in an average day?				
	Rank salt intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low	
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola	
	Number of cups/cans per day?				
<b>Alcohol</b>	Do you drink alcohol?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?				
	How many units per week? (one unit = 250ml beer, 25cl spirits, 125 ml wine)				
	Have you ever experienced blackouts?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Tobacco</b>	Do you use tobacco?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes - Number/day	<input type="checkbox"/> Chew - Number/day	<input type="checkbox"/> Pipe - Number/day	<input type="checkbox"/> Cigars - Number/day	
	<input type="checkbox"/> Number of years		<input type="checkbox"/> Or year you quit smoking		

## FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
<b>Father</b>			<b>Children</b>	<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Mother</b>				<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Siblings</b>	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b> <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather</b> <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b> <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather</b> <i>Paternal</i>		

## WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every ____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies ____ Number of live births ____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam?		

## MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times ____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**OTHER PROBLEMS**

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

**Please provide any additional information relating to your current medical problem**

Reports Attached (Tick where applicable)

<input type="checkbox"/> ECG (EKG)	<input type="checkbox"/> CT Scan	<input type="checkbox"/>
<input type="checkbox"/> X - Ray	<input type="checkbox"/> Other (please specify)	<input type="checkbox"/>
<input type="checkbox"/> Blood	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Urine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> MRI	<input type="checkbox"/>	<input type="checkbox"/>

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Consultant's/Surgeon's Remarks