Confidential Questionnaire

Answer all questions - Please print clearly **Date:** / /

Name: _____ **Sex:** _____

Address _____ **Date of Birth:** / /

_____

_____

_____

1) Do you smoke ❑ Yes ❑ No
If yes, how many per day ❑ Yes ❑ No
If no, have you ever smoked ❑ Yes ❑ No
If yes, how long off. ❑ Yes ❑ No

2) Do you drink alcohol ❑ Yes ❑ No
If yes,
How many glasses of beer _____
How many glasses of wine _____
How many glasses of spirits _____

3) Do you exercise *

Vigorously	❑ Yes	?
Moderately	❑ Yes	?
Seldom, if ever	❑ Yes	?

4) Do you eat

More than 7 servings of bread and pasta per day	❑ Yes	❑ No	?
More than 6 servings of fruit and vegetables per day	❑ Yes	❑ No	
More than two servings of meat	❑ Yes	❑ No	
More than three servings of milk, cheese and yogurt per day.	❑ Yes	❑ No	
Do you try to cut down on your intake of fatty foods	❑ Yes	❑ No	
Do you try to increase your daily intake of fibre ?	❑ Yes	❑ No	

5) General. **Notes**

Are you on treatment for high blood pressure?	❑ Yes	❑ No
Are you on treatment for high cholesterol?	❑ Yes	❑ No
Do you suffer from heart disease?	❑ Yes	❑ No
Are you on any medication, inhalers or injections?	❑ Yes	❑ No
Are you suffering from Diabetes?	❑ Yes	❑ No
Are you suffering from any serious illnesses?	❑ Yes	❑ No
Do you have a family history of glaucoma ?	❑ Yes	❑ No
Do you visit your dentist every six months	❑ Yes	❑ No
Have any of your immediate family suffered from heart disease under 55 years of age.?	❑	❑
Do you have a family history of bowel cancer?	❑ Yes	❑ No
Do you have a family history diabetes ?	❑ Yes	❑ No
If you travel a lot, do you keep your travel vaccines up to date?	❑ Yes	❑ No
Do you have any allergies to medications	❑ Yes	❑ No

Please list on back: _____

If yes, please list: _____

If yes, list them

6) Females only

Are you on the "Pill" ?	❑ Yes	❑ No
Do you regularly examine your breasts ?	❑ Yes	❑ No
Do you regularly have a cervical smear ?	❑ Yes	❑ No
If no, when was the last time you had a smear test?	❑ Yes	❑ No

7) Males only

Do you regularly examine your testicles for abnormal lumps	❑ Yes	❑ No
If over 50 years,	❑ Yes	❑ No
Do you have any difficulty passing urine	❑ Yes	❑ No
Are you frequently up at night to pass urine	❑ Yes	❑ No
Do you have difficulty starting to pass urine	❑ Yes	❑ No

Note *

Moderate activity would include:

a)	*Washing and waxing a car*
b)	Washing windows
c)	Gardening
d)	Walking 13/4 miles in 35 minutes
e)	Cycling 5 miles in 30 minutes
f)	Raking leaves
g)	Swimming laps
h)	Skipping
i)	Shovelling snow
j)	Walking stair
k)	Making beds (blankets and sheets)
l)	Hoovering
m)	Fast dancing

Heavy activities would include

Running/jogging
Aerobics
Strenuous dancing
Heavy manual labour
Competitive sports

Readings and measurements.

Item	*Reading*	
Height	**Metres**	**Inches.**
Weight	**Kg.**	**Lbs.**
Waist measurement		
Hip measurement		
Blood pressure	/	

Cholesterol	
HDL	
LDL	
Triglycerides	

Urine	❑ **Positive**	❑ **Negative**
Blood	❑	❑
Protein	❑	❑
Nitrates	❑	❑
Bilirubin	❑	❑

LUNG FUNCTION TESTS	
FVC	
FEV1	
PEFR	

VISION RIGHT EYE			**LEFT EYE**	
Distance vision	Without glasses = 6/	With glasses = 6/	Without glasses = 6/	With glasses = 6/
Reading vision	Without glasses = N/	With glasses = N/	Without glasses = N/	With glasses = N
Reading vision @ 26”	Without glasses = N/	With glasses = N/	Without glasses = N/	With glasses = N
Colour vision				
Peripheral vision				

HEARING	**NORMAL TO CONVERSATION**	
	❑ Yes	❑ No

AUDIOMETRY	

OTHER BLOOD TESTS: