Health Screening Questionnaire

Note: This questionnaire is designed to gather information about your health. Your responses will be kept confidential and used solely for medical purposes

Personal Information:

1. Full Name: ……
2. Date of Birth: …….
3. Gender: ………
4. Marital status: ………
5. Contact Information (Phone, Email): ……………………………………………………………………………
6. Address: ……

Medical History:

- How would you rate your overall health on a scale from 1 (poor) to 5 (excellent)?
  (Poor) ☐
  (Fair) ☐
  (Average) ☐
  (Good) ☐
  (Excellent) ☐
- Do you have any chronic medical conditions (e.g., diabetes, hypertension, heart disease, etc.)?
  Yes ☐
  No ☐
  If yes, please specify: ……………………………………………………………………………………………
- Have you had any previous hospital admissions?
  Yes ☐
  No ☐
  If yes, Please provide details: ……………………………………………………………………………….
- Have you had any previous blood transfusions?
  Yes ☐
  No ☐
  If yes, Please provide details: ……………………………………………………………………………….

Surgical History:

- Have you ever had surgery?
  Yes ☐
  No ☐
  If yes, Please provide details: ……………………………………………………………………………….

Gynaecological History:

a. Menstrual History

- Age at first menstruation (menarche): ______ years
- Typical menstrual cycle length: ______ days
- Duration of menstrual bleeding: ______ days
- Regularity of menstrual cycles: ☐ Regular ☐ Irregular ☐ Unsure
- History of menstrual disorders (e.g., PCOS, endometriosis):

  Yes ☐

  No ☐

If yes, please provide details: ……………………………………………………………………………………………………

b. Birth Control History

- Current or past use of contraception (e.g., birth control pills, IUD, condoms):

  Yes ☐

  No ☐

  Details of contraception used (if applicable): ………………………………………………………………………

c. Sexual History

- History of sexually transmitted infections (STIs):

  Yes ☐

  No ☐

  If yes, please provide details: …………………………………………………………………………………………

d. Pelvic Pain and Discomfort

- History of pelvic pain or discomfort:

  Yes ☐

  No ☐

  If yes, please provide details: …………………………………………………………………………………………

Obstetrics History:

- Number of Pregnancies: ______
- Number of Full-term Pregnancies: ______
- Number of Preterm or Premature Births: ______
- Number of Miscarriages: ______
- Number of Abortions or Terminations: ______
- Number of Living Children: ______

Pregnancy-Related Information

- Date of Last Menstrual Period (if pregnant or recently pregnant): ___________
- Any complications during pregnancy (e.g., gestational diabetes, preeclampsia):

Yes ☐

No ☐

- History of Caesarean Section (C-section):
  Yes ☐
  No ☐
  If yes, please provide details (frequency and indication): ………………………………………………

Additional Information

- Family history of gynaecological or obstetric conditions (e.g., breast cancer, ovarian cancer):
  Yes ☐
  No ☐
  If yes, please provide details: ………………………………………………………………………………………
- Is there any other information related to your gynaecological and obstetric history that you believe is important for your healthcare provider to know? Please share:
  ………
  ………
  ………
  ………
  ………

Male Urological Health:

- Do you experience any of the following urinary symptoms?
  Frequent urination ☐
  Urgency to urinate ☐
  Weak urine stream ☐
  Dribbling after urination ☐
  Pain or discomfort during urination ☐
  Blood in urine ☐
  Difficulty starting urination ☐
  Incomplete emptying of the bladder ☐
- Have you noticed any changes in your sexual health or function?
  Erectile dysfunction (difficulty achieving or maintaining an erection) ☐
  Premature ejaculation ☐
  Reduced libido (sex drive) ☐
  Pain during sexual activity ☐

- Have you experienced any sexual health issues or concerns (e.g., erectile dysfunction, premature ejaculation)?

  Yes ☐

  No ☐

  If yes, please describe: ……………………………………………………………………………………………………

- Have you experienced any unexplained weight loss, fatigue, or night sweats?

  Yes ☐

  No ☐

- Have you had any urological conditions or surgeries in the past?

  Yes ☐

  No ☐

  If yes, please describe: ……………………………………………………………………………………………………

- When did you last have a urological screening, including a prostate-specific antigen (PSA) test or other relevant tests? ……………………………………………………………………………………………

Medications and allergies:

- Are you currently taking any prescription medications or over-the-counter drugs or supplements?

Yes ☐

No ☐

- If yes, Please list them:

  ……

  ……

  ……

- Do you have any known allergies to medications or food?

Yes ☐

No ☐

If yes, please specify: ………

Family History:

- Are there any significant medical conditions or diseases that run in your family (e.g., heart disease, cancer, diabetes, etc.)?

  Yes ☐

  No ☐

  If yes, please specify: ……………………………………………………………………………………………………

Lifestyle and Habits:

- Do you smoke or use tobacco products?

  Yes ☐

  No ☐

  If yes, how many cigarettes/packs per day, or how much tobacco do you use?

  ……

- Do you consume alcoholic beverages?
  Yes ☐

  No ☐

  If yes, how often and how much on average? ……………………………………………………………………….

- Do you engage in regular physical activity or exercise?

  Yes ☐

  No ☐

  If yes, please describe your typical exercise routine: ……………………………………………………………….

Diet and Nutrition:

- How would you describe your diet?

  Healthy and balanced ☐

  Mostly healthy, but occasional indulgences ☐

  Could be better ☐

  Unhealthy ☐

- Do you have any dietary restrictions or specific eating habits?
  Yes ☐

  No ☐

  If yes, please specify: ……………………………………………………………………………………………………

- How often do you consume fruits and vegetables?
  Often ☐

  Rarely ☐

- Do you take any dietary supplements or vitamins regularly?
  Yes ☐

  No ☐

- How often do you engage in physical activity or exercise (e.g., walking, jogging, gym workouts)?
  Rarely or never ☐
  1-2 days per week ☐
  days per week ☐
  5 or more days per week ☐
- Can you walk or climb stairs without difficulty?
  Yes ☐
  No ☐
- Do you experience shortness of breath with light physical activity?
  Yes ☐
  No ☐
- Do you have any physical limitations or disabilities that affect your daily activities?
  Yes ☐
  No ☐

Mental and Emotional Health:

- Do you have a history of mental health issues (e.g., depression, anxiety, bipolar disorder)?
  Yes ☐
  No ☐
  If yes, please specify: ………
- Are you currently experiencing high levels of stress or have you faced any recent traumatic events?
  Yes ☐
  No ☐
  If yes, please specify: ………
- Do you have a support system for your mental and emotional well-being?
  Yes ☐
  No ☐
  If yes, please specify: ………

Additional Comments:

- Is there anything else you would like to add or share about your health that is not covered in this questionnaire?

  ……
  ……