JOINT SICKNESS SCREENING PROGRAMME
EUROPEAN UNION

Surname and forename of member:……..…

Personnel or pension No:…..…….

Beneficiary of current programme……..

Preliminary questionnaire

In order to make your screening more efficient, please complete this questionnaire very carefully, **with the help of your family doctor.**
It will provide important information for identifying possible risks to your health.
Please circle 'yes' or 'no' for each question, and fill in the answers to the other questions.

1. Your lifestyle

- Do you smoke? YES NO
  If yes, what?.....How many per day?.....

- Do you take physical exercise at least once a week?
  YES NO

  If yes, what kind?.....
  How many times a week?.....

- How many times a week, on average, do you eat:

  - red meat.....
  - fish……
  - fruit and vegetables.....
  - butter or margarine.....
  - nuts, seeds or cereals.....

- Do you normally wear a seat-belt? YES NO

- Do you drink alcohol? YES NO
  If yes, how many glasses per week?.....

- Do you take drugs? YES NO

- Do you think you are at risk of sexually transmitted diseases? YES NO

- Do you sunbathe or use sunbeds and get sunburnt or heavily tanned? YES NO

- Do you travel to tropical regions? YES NO

2. Your family background

- Are you aware of any cases of cancer in your immediate family? (especially breast, colon or skin cancer) YES NO

If yes,

Relationship to you	Type of cancer	Age when it occurred

- Are you aware of any cases of cardiovascular disease in your family? (especially heart attack, infarction, angina, sudden death before the age of 55, familial hypercholesterolemia) YES NO

If yes,

Relationship to you	Type of disease	Age when it occurred

- Are you aware of any cases of diabetes in your immediate family? YES NO

If yes,

Relationship to you	**Age when it occurred**

- Are you aware of any other types of serious hereditary diseases in your immediate family? YES NO

If yes,

Relationship to you	**Type of disease**

3. Your personal medical history

- Have you ever had or been treated for:

  - High blood pressure YES NO
  - Infarction or angina YES NO
  - Stroke YES NO
  - Arteritis YES NO
  - Diabetes YES NO
  - Hypercholesterolemia YES NO
  - Cancer YES NO

- Others? Please specify…….

- Have you ever had an operation? YES NO

If yes,

For what?	How old were you?

- Did you have a blood transfusion before 1992? YES NO

- Please give the dates of your last vaccination for:

  - Tetanus: ……

  - Diphtheria: …….

  - Poliomyelitis: ……

  - Pneumococcus: ……..

  - Influenza: ……..

  - 2nd injection for hepatitis A: ……..

  - 3rd injection for hepatitis B: ……..

- Have you had any serious or tropical diseases? YES NO

If yes, which ones?

Disease?	How old were you?

- For women: have you ever had any gynaecological diseases? YES NO

If yes, which ones?

Disease?	**How old were you?**

- How many pregnancies have you had? ……..

Any complications?

Complication?	**Which pregnancy?**

4. Treatments you are currently receiving

- Contraceptive pill: …….
- Hormone replacement therapy (HRT): …….
- Treatment for osteoporosis ……
- Other prescribed medication:

  ……..
  ……..
  ……..
  ……..
  ……..

- Medication you buy yourself:

  ……..
  ……..
  ……..
  ……..
  ……..

5. Symptoms experienced

Have you had any of the following symptoms in the last few months?

- acute chest pains	YES	NO
- calf cramp when walking	YES	NO
- changes in your bowel habits	YES	NO
- blood in the stools or black stools	YES	NO
- abnormal shortness of breath	YES	NO
- cough lasting more than three weeks	YES	NO
- blood in the phlegm	YES	NO
- unintended weight loss or gain:	YES	NO
if yes, + ……kg since……		
- ……kg since ……..		
- changes to existing skin blemishes	YES	NO
- persistent voice alteration	YES	NO
- hearing problems	YES	NO
- eyesight problems	YES	NO
If yes, what kind?.....		
- abnormal gynaecological bleeding	YES	NO
- other worrying symptoms:	YES	NO

…….
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…….

6. Recent examinations Annual results

- blood test within the last year	YES	NO
- mammogram within the last year	YES	NO
- colonoscopy	YES	NO
- bone density scan within the last two years	YES	NO
- exercise electrocardiogram dated ……	YES	NO
- eye tests	YES	NO

If you have answered yes, if possible please attach a copy of any examination reports.

Thank you for completing this questionnaire, which is an important part of the screening process. Please bring this questionnaire to your examination.