

Health Screening Questionnaire

Please Use ID Label or Block Print

SURNAME			UNIT RECORD NO.
GIVEN NAME			CHINESE NAME
SEX	AGE	WARD	ADMITTED DATE & TIME
ATTN. DOCTOR			
CONSULT. DOCTOR			

I. Personal Information

Occupation : _____

Marital Status: Single Married Widow

Family Doctor : Yes No

II. Past Medical History

1. Did you have any health check before ?

No Yes, please state the date: _____ / _____ / _____

2. Did the health check result need to follow ?

No Yes, please state: _____

3. Are you Hepatitis B carrier ?

No Unknown Yes (Any regular follow up ? Yes No)

4. Have you received Hepatitis B vaccination previously ?

No Yes, please state the date: _____ / _____ / _____

5. Do you have any regular medication ?

No Yes, please state: _____

6. Do you ever be admitted to hospital for treatment / operation before ?

No Yes, Please state: _____

III. Personal Health Condition in last year

Yes No

- | | | |
|--|--------------------------|--------------------------|
| 1. Sudden weight gain or loss (> 10 lbs) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Changes in appetite | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Sudden blackouts / faints | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Prolonged headache | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Shortness of breath or breathlessness | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Rapid / irregular heart beats | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Chest pain | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Prolonged stomach discomfort | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Indigestion | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Blood stained / black stool | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Frequency of urine | <input type="checkbox"/> | <input type="checkbox"/> |

IV. Personal Habit

1. Drinking of Alcohol

Never

Quit for _____ year(s), have drunk _____ glass(es) of _____ (wine)*everyday / every week

Drink _____ glass(es) of _____ (wine)*everyday / every week

Social drink _____ glass(es) of _____ (wine) every time

HMC-060m-11-1658e(R)

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2. Smoking

- Never
- No, but always as second smoker
- Quit for _____ year(s), have _____ cigarettes per day before
- Smoking for _____ year(s), have _____ cigarettes per day
- Only have _____ cigarette(s) taken in social gathering

3. Physical Exercise

- Job Mature: Physical labor Slight physical labor Clerical work
- I spent sitting for _____ hour(s) everyday
- I spent walking for _____ hour(s) everyday
- Regular exercise: Always, I have exercise _____ time(s) per week(continue exercise>20mins)
- Sometimes, I have exercise _____ time(s) per week(continue exercise>20mins)
- Seldom, reasons for not having regular exercise:
- No time Not enough endurance Tiredness No partner support
- Others: _____

4. Sleeping Pattern (based on pattern in one week)

- Good quality and sufficient sleep (7 hours or above)
- Insomnia (always)
- Insomnia (sometimes)
- Insufficient sleep
- Difficult to fell asleep

5. Eating (Nutrition status)

- Regular meal (Breakfast, Lunch, Supper) Always Sometimes Seldom Never
- Snacks between meals Always Sometimes Seldom Never
- Frequency of having meals outside _____ times / week
- I think my body weight is Ideal Below weight Over weight
- I have vegetable and fruits Always Sometimes Seldom Never
- I have food in grease and high cholesterol Always Sometimes Seldom Never
- I have food with high glucose level Always Sometimes Seldom Never
- I have nutritious food Always Sometimes Seldom Never

V. Family Health History (please state the relationship and age of onset)

- | | | | |
|---------------------------------------|-------------------------------|--|-------------------------------|
| <input type="checkbox"/> Hypertension | Relationship: _____ age _____ | <input type="checkbox"/> Heart Disease | Relationship: _____ age _____ |
| <input type="checkbox"/> Stroke | Relationship: _____ age _____ | <input type="checkbox"/> Diabetes | Relationship: _____ age _____ |
| <input type="checkbox"/> Lung Disease | Relationship: _____ age _____ | <input type="checkbox"/> Renal Disease | Relationship: _____ age _____ |
| <input type="checkbox"/> Cancer | Relationship: _____ age _____ | <input type="checkbox"/> Thyroid Disease | Relationship: _____ age _____ |
| <input type="checkbox"/> Epilepsy | Relationship: _____ age _____ | <input type="checkbox"/> Others | Relationship: _____ age _____ |

VI. Signature of Client: _____ Date : _____

Remarks: ✓ the appropriate box.

* Circle the appropriate items