Questionnaire

Date / / /

ID _____

Name _____

Why are you visiting our hospital?

□ Having any symptoms □ Referral from another hospital/clinic

□ Abnormal findings on the screening test □ Regular check up

If you have any symptoms, please check all that apply and describe in detail below.

□ Chest pain □ Abnormal heartbeats □ Shortness of breath □ Swollen legs

□ Leg pain □ Other ( )

.....

.....

.....

Are you currently taking any medication?

□No □Yes If yes, please list: .....

.....

Are you allergic to any medication, foods or metals?

□No □Yes If yes, please list: .....

Do you smoke?

□Never □ I quit. (How long ago?) □Yes, currently. (cigarettes/day, for years

Do you drink alcohol?

□No □Yes If yes, (How often? days a week), (what kind of alchohol?

Do you have now or have you ever had any of the following diseases?

Please check all that apply.

□ Hypertension □ Diabetes □ Hyperlipidemia □ Gout □ Asthma □ Kidney disease

□ Heart disease □ Stroke □ Glaucoma □ Thyroid disease

□ Other ( )

Have you ever had any operations before?

Types of operation / reasons for operati	Age at operation
.....	(years old)
.....	(years old)
.....	(years old)

Do you have any family members who have had any of the following disease?

Please check all that apply and indicate the relationship to you in the bracket.

□ Heart disease ( )

□ Stroke ( )