**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (yours): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact of Next of Kin (preferable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation (current or former): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any known **allergies**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous illnesses** (including a history of stroke or heart attack), **injuries, operations** (such as tonsil or oesophagus removal, appendix removal, gallbladder removal, gynaecological operations, caesarean sections, etc.):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indicate if you have any of the listed conditions and specify, if known, when they were diagnosed:

|  |  |  |  |
| --- | --- | --- | --- |
| CONDITION: | YES | NO | Date of diagnosis: |
| **High blood pressure - arterial hypertension** |  |  |  |
| **Diabetes** |  |  |  |
| **Asthma** |  |  |  |
| **COPD - chronic obstructive pulmonary disease** |  |  |  |
| **Kidney disease - chronic kidney disease** |  |  |  |
| **Osteoporosis** |  |  |  |
| **Depression** |  |  |  |
| **Epilepsy** |  |  |  |

Write down **which medication** you take and **when**.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | medication: | Intake schedule: |  |  | medication: | Intake schedule: |
| 1 |  |  |  | 6 |  |  |
| 2 |  |  |  | 7 |  |  |
| 3 |  |  |  | 8 |  |  |
| 4 |  |  |  | 9 |  |  |
| 5 |  |  |  | 10 |  |  |

**FAMILY HEALTH HISTORY**

Has anyone in your family (referring to your parents, grandparents, brothers, or sisters) experienced or currently has any of the following conditions:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | YES | NO | I DON'T KNOW |  |
| High blood pressure |  |  |  | \* Mark “Yes” if your relative was under 55 years old (male) or under 65 years old (female) at the time of the event. |
| Diabetes |  |  |  |
| Heart attack \* |  |  |  |
| Stroke \* |  |  |  |
| Asthma, chronic bronchitis, COPD |  |  |  |
| Cancer # |  |  |  |  |

# If you responded with YES, please specify the type of cancer and which family member it affected. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SMOKING**

1)I don't smoke.  
2) I quit smoking \_\_\_\_ year/s ago.  
3) I smoke \_\_\_\_\_\_ cigarettes per day for \_\_\_ years.

**DRUGS** 1 – NO 2 – YES, which: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALCOHOL**

1. How often have you consumed alcoholic beverages (beer, wine, spirits, liqueurs, cocktails, cider…) in the last year?

0) Never

1) Once a month or less

2) 2 to 4 times a month

3) 2 to 3 times a week

4) 4 or more times a week

2. How many units of alcoholic beverages have you consumed in the time indicated in the previous question? (One unit is equivalent to a standard drink size – e.g. 1 dcl of wine, 2.5 dcl of beer or cider, or 0.3 dcl of spirit.)

0) From 0 to 1 unit

1) 2 units

2) 3 or 4 units

3) 5 or 6 units

4) 7 and more units

3. How often have you had 3 or more units if **female**, or 5 or more if **male**, on a single occasion in the last year?

0) Never

1) Less than once a month

2) 1 to 3 times a month

3) 1 to 3 times a week

4) Daily or almost every day

**RECREATIONAL ACTIVITY** (lasting at least 20 – 30 minutes):

Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Regularly (3-5 times a week)
2. Occasionally (how often) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Never