HARLEY STREET MEDICAL EXPRESS CLINIC
Love all, serve all.

MEDICAL EXPRESS HEALTH AND WELLBEING QUESTIONNAIRE
STANDARD (SILVER) HEALTH MOT: Measurements, Observations, Tests❒
Section A – Health and Lifestyle Questionnaire: About you

There are Male and Female questions, please fill those as appropriate. There are questionnaire on sex and sexuality. Please leave items blank if you wish not to answer. Thank you.
Please give us as much details as possible.
If you wish not to fill any section of this questionnaire, please leave it blank. Thank you.

A. PERSONAL DETAILS

Forename: ___________________________________ Surname: ______________________________

Title: Mr ❒ Mrs ❒ Dr ❒ Professor ❒Sir ❒ Madam ❒ Other❒, state____________________

Date of Birth: ___________________________________ Country of Birth: _____________
Date Month Year

Address (where your report will be sent): ____

____ Postcode: ________________________________

Daytime telephone: ___________________________ Mobile: ________________________________

Evening telephone: ____________________________ E-mail:________________________________

Have you had similar health screening/health MOT before? No ❒ Yes ❒

If yes was it at our clinic? Yes ❒ No❒, please state where and when: _______________________

Do you have the report? Yes ❒ No❒

Note: If you had Health MOT before, please bring the report for review. Thank you.

B. OCCUPATIONAL HISTORY

Are you now – Student ❒ Looking for work ❒ Home person ❒ Working person ❒ Pensioner ❒

If not working have you ever worked? Yes ❒ No ❒ If yes, please continue with the next questions. If no, please go to Section C.

Are you working at present? Yes ❒ No ❒ If no, what was your last job? ____________________
Your occupation: _____________________ Number of hours you work per week:________________
Do you find your job fulfilling? Yes ❒ No ❒ If no, please give details__________________________
____
Number of days off sick in the last 12 months: [ ] days.

Reason for sick leave: ____________________________ if you are houseparent please tick here ❒

Do you consider your job stressful? Yes ❒ No ❒

How does this affect you? Not at all ❒ or state: ____

Are you aware of any occupational health hazards associated with your work? Yes ❒ No ❒

If yes, please state: ____

If you wish to state anything about your job, which we should be aware, please state here___

C. MEDICAL HISTORY

1. Please state any serious illness or major surgery you have had in the past (give approximate dates):

2. Are you currently suffering from any illness, allergy or anaphylaxis? No ❒ Yes ❒

If yes, please state details: ____

3. If you have allergy Yes ❒ No❒, please fill the Allergy Questionnaire, later in this Questionnaire.

4. Do you have any allergy history for medication or bee sting etc.: Yes ❒ No ❒

If yes, please state: ____

5. Are you currently on any medication(s)? No ❒ Yes ❒

If yes, please state details:

MEDICATION	DOSE	FROM WHEN	WHY (INDICATION)

6. Are you under any specialist or consultant for any health problem, at present? No❒ Yes ❒

If yes, please state details: ____

If you have any medical reports please bring or enclose them and tick here ❒

If you have reports, but they are not available now, please tick here ❒ Please state how we can get these and give written consent for us to obtain. Thank you ❒

7. Have you ever had a mental health problem? No❒ Yes ❒

If yes, is it: Depression ❒ Anxiety Disorder ❒ Panic attack ❒

or other, please state: ____

D. RELATIONSHIP STATUS

(If you do not feel comfortable filling this section, please leave it blank and tick here❐)

Please indicate your 'personal' relationship status at the present time:

Single ❐ Married ❐ Long Term Relationship❐ Divorced/Separated❐ Widowed❐ Cohabiting❐

Other ❐ state: ___________________________

For how long have you been in this personal relationship status? _______________ months/years

Please state any significant changes to your relationship status in the last 5 years: _____________

____

Are you: Bisexual ❐ Homosexual ❐ Lesbian ❐ Other❐, state:_______________________

If currently in a relationship:

Details of the partner (if it is ok with your partner): Name: _____________________________

Date of Birth________________________

Is your partner in good health? Yes ❐ No ❐

Do you consider that you are in a stable relationship? Yes ❐ No ❐

Do you feel your relationship causes you stress more often than not? No ❐ Yes ❐

Do you feel your relationship is stable and supportive? Yes ❐ No ❐

Are you happy and fulfilled in this partnership? Yes ❐ No ❐

Do you feel you have adequate support from family and friends? Yes ❐ No ❐

Is there anything you want to tell us about your relationship? No ❐ Yes ❐ If yes, state________

____

E. PERSONAL LIFE HISTORY

Children

Have you any children? No ❐ Yes ❐ If yes, write in your children's ages if applicable.
(if more than 4 children, write in a separate sheet)

	Child's Name	Date of Birth	Sex	Birth Weight	State of Health
1.					
2.					
3.					
4.					

Do your children have any significant medical or educational problems? No ❐ Yes ❐ If yes, state:

____

Women only answer the following questions.

Did you have any termination of pregnancy for medical reasons? No ❒ Yes ❒ If yes, state: _____
____

Did you have any miscarriage (of pregnancy) No ❒ Yes ❒ If yes, state: ____________________
____

Family History

If you have been adopted, fostered or other, please tick one of the following boxes below:

Fostered ❒ Adopted ❒ Other❒ If other, please give details__________________________
____

If you have not been adopted, fostered or other please write in your relatives' details.

Your family history:
(if more than 2 brothers/sisters, write in a separate sheet)

Relation	Age	State of Health	If Dead, Age at Death	If Dead, Cause of Death
Father				
Mother				
Brother				
Brother				
Sister				
Sister				

Do you have (or did you have) any blood relatives with health problems (i.e. high blood pressure, heart problems, stroke, diabetes, cancer or thyroid disorder)? No ❒ Yes ❒ If yes, state: ____
____

Do you have (or did you have) any close relatives who had cancer? No ❒ Yes ❒ if yes, please state: ____

F. PERSONAL LIFESTYLE

Smoking

Have you ever smoked? No, I never smoked ❒ please go to the last two questions marked *

I used to smoke, but I stopped [ ] years ago / [ ] months ago ❒

Yes, I smoke ❒ I started to smoke at [ ] years of age.

If you smoke, how many cigarettes/cigars/ pipe do you smoke at present?

☐ Cigarettes per day ☐ cigars per day ☐ pipe per day

Are you aware that smokers should have regular chest X-ray to look for lung cancer? Yes ❒ No ❒

If yes, when was your last chest x-ray?

____

Would you like to quit smoking? Yes ❒ No ❒ Discuss with the doctor.

Would you like to have hypnosis or acupuncture ❒ treatment at our clinic privately? No ❒ Yes ❒

* If you do not smoke, are you a regular passive smoker? No ❒ Yes ❒

* Are you aware of the effects of passive smoking? Yes ❒ No ❒

(Please see our website 'www.medicalexpressclinic.com' at the Section … to get advice on how to quit smoking)

Alcohol

Have you ever drunk alcohol? No, I am a teetotaller ❒ please go to the last two questions marked *

I used to drink alcohol, but I stopped ☐ years ago/ ☐ months ago ❒

Yes, I drink alcohol ❒

If you are a drinker, what do you usually drink? Beer ❒ Wine ❒ Spirit ❒ Other❒, state: ________

____

How many units of alcohol[1] do you drink per day? ☐ units
(If you do not know what a unit of alcohol is, please see the footnote at the bottom of the page)

How many days a week do you drink that quantity? ☐ days

How many units of alcohol do you drink a week? ☐ units

Are you aware that food slows alcohol's absorption and effects? (no cardiovascular benefits) Yes❒ No❒

If no, will you try to eat while drinking alcohol now? Yes ❒ No ❒

Have you ever thought about cutting down your drinking? Yes ❒ No ❒

Have you ever been annoyed by criticism on your drinking? Yes ❒ No ❒

Have you ever felt guilty about your drinking? Yes ❒ No ❒

Do you drink in the morning (as soon as you wake up)? Yes ❒ No ❒

Are you aware of the harmful effects of alcohol to the baby if a pregnant woman drinks? Yes❑ No❑

Are you aware of the health effects of drinking alcohol? Yes❑ No❑

You also can see advice on alcohol in the Section….of our website: www.medicalexpressclinic.com

Exercise

Do you regularly play sports or take exercise? No ❑ Yes ❑ If yes, please specify ______________

____

Do you take 30 minutes exercise per day for at least five days a week, as recommended? Yes❑ No❑

Does the exercise makes you go out of breath? Yes❑ No❑

Are you aware of the benefits of exercise for health? Yes❑ No❑

If you would like to read more about the good effects of exercise for health, please visit our website at the Section …

1. One unit of alcohol corresponds to half a pint of ordinary strength beer/cider/lager (such as Budweiser or Carlsberg); one quarter of a pint of strong beer, cider or lager (such as Stella); one small glass of wine (120 ml); one single (pub 25 ml) measure of spirits; one small glass of sherry.

Diet

Do you consider your diet to be healthy? Yes❑ No❑

Do you have any food allergies? No❑ Yes❑ If yes, state details: ____________________________

____

Are you vegetarian? No❑ Yes❑ If yes, is it from birth ❑ or from when: ____________________

Are you on any special diet? No❑ Yes❑ If yes, state details: ______________________________

____

How many portions of fruit[2] do you eat a day? 0 ❑ 1❑ 2❑ 3❑ 4❑ 5❑

How many portions of vegetables[3] do you eat a day? 0 ❑ 1❑ 2❑ 3❑ 4❑ 5❑

How many glasses (250ml) of fruit juice do you drink a day? 0 ❑ 1❑ 2❑ 3❑ 4❑ 5❑

How many glasses of water do you drink a day? 0 ❑ 1❑ 2❑ 3❑ 4❑ 5❑

How many cups of tea or coffee do you drink per day? 0 ❑ 1❑ 2❑ 3❑ 4❑ 5❑

How many times a week do you eat	0	1	2	3	4	5
fish?	❒	❒	❒	❒	❒	❒
red meat?	❒	❒	❒	❒	❒	❒
wholemeal grains high fibre cereals? (including brown rice, whole wheat pasta, muesli, shredded wheat, etc.)	❒	❒	❒	❒	❒	❒
cheese?	❒	❒	❒	❒	❒	❒
eggs?	❒	❒	❒	❒	❒	❒
"healthy bacteria" (probiotics)?	❒	❒	❒	❒	❒	❒
convenience food?	❒	❒	❒	❒	❒	❒

Do you make efforts to cut salt in your diet? Yes❒ No❒

Do you take any vitamin/mineral supplements? No❒ Yes❒ If yes, please write which ones and from when: ____

Coffee: how many cups of coffee do you drink a day on average? ❒
Do you know that 2 to 5 cups of coffee a day is good for cardiovascular health? Drinking more than that is not beneficial.
Is there anything else you would like to tell us about your diet/nutrition? No❒ Yes❒ If yes, please state details____
____

you can find advice on diet/nutrition for health in our website at the Section…

2 One portion of fruit corresponds to one apple or banana or pear or two slices of pineapple or a small bowl of fruits.
3. One portion of vegetables corresponds to two tablespoons of vegetables or one dessert bowl full of salad.

Sleep

Do you have sleep problems? No❒ Yes❒ If yes, please state details______________________
____

Do you snore during sleep? (ask your partner if you snore) No ❒ Yes ❒
Do people tell you that you snore? No ❒ Yes ❒
Has anyone ever told you that you gasp for breath when you sleep? No ❒ Yes ❒

(Do you know that we have a symbiotic relationship with a sleep clinic in the same building? If you are interested, ask for details or visit sleeprhythmstresscentre.com or bocsleepcentre.com)

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Stress

Do you consider yourself under stress at present? No❑ Yes❑ If yes, please give reasons for your stress: ____

Have you: Lost much sleep through worry? No❑ Yes❑

Lost interest in activities you once enjoyed? No❑ Yes❑

Found it difficult to concentrate or make decisions? No❑ Yes❑

Experienced restlessness or decreased activity? No❑ Yes❑

Felt constantly under strain? No❑ Yes❑

Lost your sex drive? No❑ Yes❑

(Do you need advice on how to improve your sex life? Please tick here. ❑ We can arrange an appointment with doctor who has a special interest in sex medicine.)

If you answered 'yes' to more than two of the above questions, you may wish to check if you are mildly depressed or just feeling a bit down. Please fill the next Section: Becks. Depression Inventory.

If you do not feel comfortable in filling it, please tick here ❑. Depression (and anxiety) Questionnaire is optional, although we strongly recommend it, because by filling it, you may score up yourself and if you wish to see a specialist psychiatrist to discuss your situation in details, please feel free to ask more information. Just tick here ❑

Would you like hypnotherapy by our hypnotherapist? Please ask. ❑

Please visit our website at the Section …for more info about stress and health

Depression

Beck Depression Baseline Inventory

This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the statement in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16(Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

Name:____Marital Status: _________________

Age: ______Sex: ________ Occupation: ____

Education: ____

1. Sadness

[0] I do not feel sad.
[1] I feel sad much of the time.
[2] I am sad all the time.
[3] I am so sad or unhappy that I can't stand it.

2. Pessimism

[0] I am not discouraged about my future.
[1] I feel more discouraged about my future than I used to be.
[2] I do not expect things to work out for me.
[3] I feel my future is hopeless and will only get worse.

3. Past Failure

[0] I do not feel like a failure.
[1] I have failed more than I should have.
[2] As I look back, I see a lot of failures.
[3] I feel I am a total failure as a person.

4. Loss of Pleasure

[0] I get as much pleasure as I ever did from the things I enjoy.
[1] I don't enjoy things as much as I used to.
[2] I get very little pleasure from the things I used to enjoy.
[3] I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

[0] I don't feel particularly guilty.
[ ] I feel guilty over many things I have done or should have done.
[2] I feel quite guilty most of the time.
[3] I feel guilty all of the time.

6. Punishment Feelings

[0] I don't feel I am being punished.
[1] I feel I may be punished.
[2] I expect to be punished.
[3] I feel I am being punished.

7. Self-Dislike

[0] I feel the same about myself as ever.
[1] I have lost confidence in myself.
[2] I am disappointed in myself.
[3] I dislike myself.

8. Self-Criticalness

[0] I don't criticize or blame myself more than usual.
[1] I am more critical of myself than I used to be.
[2] I criticize myself for all of my faults.
[3] I blame myself for everything bad that happens.

Subtotal Page1 [ ]

9. Suicidal Thoughts or Wishes

[0] I don't have any thoughts of killing myself.
[1] I have thoughts of killing myself, but I would not carry them out.
[2] I would like to kill myself.
[3] I would kill myself if I had the chance.

10. Crying

[0] I don't cry more than I used to.
[1] I cry more than I used to.
[2] I cry over every little.
[3] I feel like crying, but I can't.

11. Agitation

[0] I am no more restless or wound up than usual.
[1] I feel more restless or wound up than usual.
[2] I am so restless or agitated that it's hard to stay still.
[3] I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

[1] I have not lost interest in other people or activities.

16. Changes in Sleeping Pattern

[0] I have not experienced any change in my sleeping pattern.

[1a] I sleep somewhat more than usual.
[1b] I sleep somewhat less than usual.

[2a] I sleep a lot more than usual.
[2b] I sleep a lot less than usual.

[3a] I sleep most of the day.
[3b] I wake up 1-2 hours early and can't get back to sleep.

17. Irritability

[0] I am no more irritable than usual.
[1] I am more irritable than usual.
[2] I am much more irritable than usual.
[3] I am irritable all the time.

18. Changes in Appetite

[0] I have not experienced any change in my appetite.

[1a] My appetite is somewhat less than usual.
[1b] My appetite is somewhat greater than usual.

[2a] My appetite is much less than before.
[2b] My appetite is much greater than usual.

[3a] I have no appetite at all.
[3b] I crave food all the time.

19. Concentration Difficulty

[0] I can concentrate as well as ever.

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2 I am less interested in other people or things than before. 3 I have lost most of my interest in other people or things. 4 It's hard to get interested in anything.	1 I can't concentrate as well as usual. 2 It's hard to keep my mind on anything for very long. 3 I find I can't concentrate on anything.
13. Indecisiveness 1 I make decisions about as well as ever. 2 I find it more difficult to make decisions than usual. 3 I have much greater difficulty in making decisions than I used to. 4 I have trouble making any decisions.	**20. Tiredness or Fatigue** 0 I am no more tired or fatigued than usual. 1 I get more tired or fatigued more easily than usual. 2 I am too tired or fatigued to do a lot of the things I used to do. 3 I am too tired or fatigued to do most of the things I used to do.
14. Worthlessness 1 I do not feel I am worthless. 2 I don't consider myself as worthwhile and useful as I used to. 3 I feel more worthless as compared to other people. 4 I feel utterly worthless.	**21. Loss 0f Interest in Sex** 0 I have not noticed any recent change in my interest in sex. 1 I am less interested in sex than I used to be. 2 I am much less interested in sex now. 3 I have lost interest in sex completely.
15. Loss of Energy 1 I have as much energy as ever. 2 I have less energy than l used to have. 3 I don't have enough energy to do very much. 4 I don't have enough energy to do anything.	Subtotal Page 1 _______________ Subtotal Page 2 _______________ Total score 1+2 = _______________

G. DAYTIME SLEEPNESS AND EXCESSIVE TIREDNESS QUESTIONAIRE.

Some people feel extremely tired or nodd off after a good night sleep.

Do you sleep well at night? Yes❐ No❐

If you sleep well:

1) Do you feel sleepy during day time? No❐ Yes❐

2) Do you feel excessively tired during day time? No❐ Yes❐

3) Do you "nodd off" while driving or similar activity? No❐ Yes❐

4) Do you "nodd off" in public transport? No❐ Yes❐

5) Do you "nodd off" at work? No❐ Yes❐

6) Do you yawn during day time? No❐ Yes❐

If you answered NO at all the 6 questions above, please go to next section.

If you answered YES to any of the questions, please continue to fill the next section, which will help to detect sleep disorders.

G. ALTERNATIVE AND COMPLEMENTARY MEDICINE USAGE

Do you take any HERBAL medicine now? No❐ Yes❐ If yes, please state what and why you take

____

____

Do you take any OVER THE COUNTER medicine now? No❐ Yes❐ If yes, please state what and why you take ____

____

Do you take any NUTRITIONAL SUPPLEMENTS now? No❐ Yes❐ If yes, please state what and why you take ____

____

Do you take any "BIOLOGICS" (prescribed by doctor or over the counter) now? No❐ Yes❐ If yes, please state what and why you take____

____

Do you take any "good bacteria" yogurt (also called probiotics) now? No❐ Yes❐ If yes, please state what and why you take____

____

Did you ever have acupuncture in the past? No❑ Yes❑ If yes, for what reason? ____

____

H. CANCER PREVENTION

1. Do you have a family history of cancer in first degree relatives (your mother, father, sister, brother, and siblings)? No❑ Yes❑ If yes, please be specific (cancer can ran in family and can be screened and genetic tests are available.)

2. The following cancer in particular:

a) Do you have a family history of breast cancer? No❑ Yes❑ If yes, please state_______________

b) Do you have a family history of cervical cancer? No❑ Yes❑ If yes, please state _______________

c) Do you have a family history of testicular cancer? No❑ Yes❑ If yes, please state ____________

d) Do you have a family history of bowel cancer? No❑ Yes❑ If yes, please state __________________

e) Do you have family history for ovarian cancer? No❑ Yes❑ If yes, please state ________________

f) Do you have family history for skin cancer? No❑ Yes❑ If yes, please state ________________

If you wish to discuss the BRCA1 and BRCA2 blood test to assess your cancer risk if you have a strong family history of cancer, please thick here ❑. Ask the doctor

I. DETECTION OF COPD (CHRONIC OBSTRUCTURE PULMONARY DISEASE)

Every minute 1 person is dying of COPD, so we will check for this condition, respiratory symptoms and peak-flow or lung function test. If you are 40 years and over, please fill this Section of Questionnaire. COPD is rare in young person.

Allergy history questionnaire for children and young person under 16 years old. If you don't have any allergy, tick here ❑ and leave this section blank.

If you have an allergy to any food, medicine, peanut, bee sting etc., please tick here ❑

Or tick no allergy known❑

If you think you may have allergy, please fill this questionnaire and think about your allergy.

To be completed by mother (if patient is a child).

If possible you may like to ask your mother about your allergy in childhood.

Allergy can begin in the womb because foetus is predisposed to atopy as a genetic condition. From this questionnaire finding we will get your **allergy history score**. The higher the score, more the chances of having atopy.

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A. In the womb-in utero.

A.1 Was the baby overactive in the womb? . No❐ Yes❐

A.2 Similarly some babies are very quiet in the womb.

Did you notice extreme quietness of your baby in the womb? No❐ Yes❐

A.3 Babies can get hiccoughs in the womb when you can notice your baby having them.

Did you notice hiccoughs? No❐ Yes❐

If yes, do you know which food triggering the hiccoughs? Please write__________________________

A.4 Babies are sometimes tensed up in the womb as a result of allergy to the food you took. Was the baby stiff at birth? Did you notice this? No❐ Yes❐

A.5 Some babies are floppy at birth due to allergy in the womb. Was your baby floppy? Did you notice this in the first few days? No❐ Yes❐

B. Condition of skin at birth:

B.6. Eczema or very dry skin can be present at birth or in the first week of life.

Did you notice? - Eczema❐ ; Dry skin ❐; Cracked skin at birth or soon after❐

C. Feeding:

C.7 Babies with allergy are generally speaking are poor feeders. Did you notice this? No❐ Yes❐

C.8 They vomit or posset a lot. Did you notice excessive vomiting or posseting No❐ Yes❐

C.9 Get colic a lot. Did your baby cry a lot due to colic? No❐ Yes❐

C.10 Needed colic medication for over 1 month. Did you give colic medication? No❐ Yes❐

If yes, what medication____

D. Behaviour:

D.11 Allergic tension-irritable and very alert most of the time in the first year. No❐ Yes❐

D.12 Allergic tension-fatigue syndrome. Was your baby tenced or irritable a lot of time? Like Jackle and Hyde personality? At one time tensed and irritable and other time sleepy and quite? No❐ Yes❐

E. Multisystem disorder:

Allergy is a multisystem disorder meaning it can effect lungs, gut, kidney, skin, brain etc.

Please tick if your child had:

E13. Eczema No❐ Yes❐

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E14. Asthma No❑ Yes❑

E15. Rhinitis No❑ Yes❑

E16. Abdominal pain No❑ Yes❑

E17. Diarrhoea No❑ Yes❑

E18. Constipation No❑ Yes❑

E19. Otitis (glue-ear) No❑ Yes❑

E20. Irritability No❑ Yes❑

E21. Tension and fatigue No❑ Yes❑

E22. ADHD No❑ Yes❑

E23. Migraine No❑ Yes❑

E24. Epilepsy No❑ Yes❑

E25. Joint pain No❑ Yes❑

E26. Bedwetting No❑ Yes❑

E27. Passing urine several times in the day No❑ Yes❑

F. Triggers:

F29. Do you know what brings on your child's symptoms? No❑ Yes❑

If yes, what? Please state: ____

Please list the triggers: foods, inhalants, contact substances etc.

F29. Have you observed symptoms improvement when you cut or remove the trigger substance?

No❑ Yes❑

When did your baby have cow's milk as Formula milk? ________________________________

When you gave Formula milk, did the baby develop any symptoms? No❑ Yes❑

When did you give wheat (gluten) containing foods? __________________________________

Did wheat (gluten) upset the baby in any way? No❑ Yes❑

G. Family history:

G30. Is there a family history of allergy? No❑ Yes❑

G31. Who is allergic in the family? Please, state name and relationship ________________________

G32. Was it food allergy? No❑ Yes❑

G33. Was it inhalant allergy? No❑ Yes❑

G34. Do you have anyone in your family who had peanut allergy? No❑ Yes❑

G35. Do you know anyone in your family who had anaphylaxis? No❑ Yes❑

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1. COPD RISK FACTOR ASSESSMENT

1.1 Asthma and Chest Infections

1.1.1Does anyone close in your family have (had) COPD or asthma?

1.1.2Did you have asthma ever? No❑ Yes❑If yes, please state details____________________________

1.1.3Did you have a lot of chest infections? No❑ Yes❑ If yes, please state details _______________

____

1.2 Smoking (Smoking is the biggest risk factor for developing COPD)

Do you smoke, now? No❑ Yes❑ If yes, please state details ___________________________________

____

Did you smoke ever? No❑ Yes❑ If yes, please state details __________________________________

____

How many years did you smoke in total ________________

How many cigarettes per day on average did you smoke? (smoking is not only cause of lung cancer, it triggers asthma and is an important cause for COPD and myocardia infart-heart attack.)

2. COPD SYMPTOMS

2.1 Cough

Do you have cough in the night? No❑ Yes❑ If yes, please state details ________________________

____

Do you have cough first thing in the morning? No❑ Yes❑ If yes, please state details ____________

____

Do you bring up sputum? No❑ Yes❑ If yes, please state details ______________________________

____

Do you wheeze? No❑ Yes❑ If yes, please state details _____________________________________

____

2.2 Shortness of breath

Do you get short of breath when walking (while others walk easily)? No❑ Yes❑

Do you get short of breath when you climb up a few steps (while others climb them without any difficulties)? No❑ Yes❑

3. TESTS

3.1 Lung Function Test – Spirometry (please discuss with the nurse)

Have you ever had Spirometry or Peak flow Assessment? Yes❑ No❑ If yes, what was your best peak flow? _____________

If you never had one and like to have one now, please tick this box ❑ you will need to pay £5 if this is NOT part of the Health MOT package. Peak flow will be done as part of Standard MOT.

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J. BODY FAT

Carrying excessive fat is not healthy. Fat cells produce inflammation which affects the heart and arteries. Excessive body fat triggers diabetes.

J.1 Do you think you are overweight? No❒ Yes❒ If yes, what actions are you taking to reduce your body weight? ____

____

J.2 Do you wish to have your body fat analysis carried out today (if it is not part of the MOT programme)? Yes❒ No❒. It will be done as a part of Standard MOT; others will pay £10.

Note: 1. In our clinic we provide the fat reduction treatment through CRYO-LIPO THERAPY, using an innovative and non-invasive FDA approved technology. We believe that it delivers results far better than any other lipo therapy. This FDA approved therapy can destroy 26% of fat in just one session at each treatment area of treatment. We may be able to treat two treatment areas in one day – giving you two treatments over nearly two hours in one day.

If you are interested in getting more information about how Cryo – Lipo therapy works, please tick here ❒ A member of our team will be happy to help you.

2. We have a Weight and Wellness Clinic run by an experienced doctor interested in weight management. Do you wish to attend this clinic? No❒ Yes❒.

This clinic is run by an experienced doctor working in this area of medicine. The doctor will assess you and will suggest treatment option with you. You can arrange to attend this clinic – you pay £79 instead of£350 for your assessment.

K. ACUPUNCTURE

K.1. Have you ever had acupuncture? No❒ Yes❒ If yes, why and when?

____

K.2. Would you consider acupuncture as a treatment modality? No❒ Yes❒ If yes, please note we have a doctor who can do acupuncture – Medical acupuncture.

L. BEAUTY THERAPY

L.1. Have you ever had any beauty therapy? No❒ Yes❒

If yes, would you like our doctor at the clinic to see you to discuss any therapy you may wish to consider? No❒ Yes❒

If yes, please consent by ticking this box for us to give your contact for our doctor to contact you. ❒

L.2. SCARS. If you have scars, moles/lumps etc., we have a plastic surgeon who can see you to discuss treatment option. Do you wish to give us your contact details? No❒ Yes❒ No need❒

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Women Only Questions: You may not fill any part if you do not wish to answer.

Present Pelvic Symptoms (for women only)

Have you any troublesome vaginal discharge? No ❒ Yes ❒

Do you have any pain or soreness during or after intercourse? No ❒ Yes ❒

Is there any bleeding after intercourse? No ❒ Yes ❒

Do you have difficulty passing or controlling urine? No ❒ Yes ❒

Do you have any problem controlling your bowels? No ❒ Yes ❒

Do you have pain or discomfort in your abdomen? No ❒ Yes ❒

Contraception

Are you sexually active now? Yes ❒ No ❒

If you currently use contraception which method do you use? ______________________________

For how long have you used it? _______________Months ___________Years

Have you used other forms of contraception? No ❒ Yes ❒

If yes, which method and for how long? ____

Have you had any gynaecological operations or investigations? No ❒ Yes ❒

If yes, please give details: ____

Do you wish to have an implantable contraceptive device? No ❒ Yes ❒

If yes, ask to nurse. You need to book an appointment to our doctor.

When did you last have a smear test? Never ❒

Last had _____ years ago.

Do you wish us to arrange a cervical smear? No ❒ Yes ❒

When was your last mammogram? ____

Was it normal? No ❒ Yes ❒

If any not normal, please tell us the concerns :

____

Orgasm (Female Orgasm Disorder)

Are you concerned about your sex matters or lack of orgasm? No ❒ Yes ❒

If yes, do you wish to see an experienced doctor/ therapist to discuss these sex matters?

No ❒ Yes ❒ If yes, please give more details:

____

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Men Only Questions: You may not fill any part if you do not wish to answer.

International Index of Erectile Function (IIEF)

The International Index of Erectile Function (IIEF) below has been developed by leading experts to help on the assessment; whether you could be suffering from erectile dysfunction (ED). The IIEF asks basic questions and you should answer as honestly as you can.

The International Prostate Score (IPS), is a validated recall tool used in the assessment of Lower Urinary Tract Symptoms (LUTS) in men. Please fill this questionnaire too.

Choose just ONE response from EACH question (A-F) based on the past 4 weeks and write the corresponding number in the box next to the question.

A. Over the past 4 weeks, how often were you able to get an erection during sexual activity? ❐ 1. Almost never/ never ❐ 2. A few times (much less than half of the time) ❐ 3. Sometimes (much more than half of the time) ❐ 4. Most times (much more than half the time) ❐ 5. Almost always/always ❐	D. Over the past 4 weeks, during sexual intercourse, how often were you able to maintain your erections after you had penetrated (entered) your partner? 1. Almost never/ never ❐ 2. A few times (much less than half of the time) ❐ 3. Sometimes (much more than half of the time) ❐ 4. Most times (much more than half the time) ❐ 5. Almost always/always (entered) your partner? ❐
B. Over the past 4 weeks, when you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)? 1. Almost never/never ❐ 2. A few times (much less than half of the time) ❐ 3. Sometimes (much more than half of the time) ❐ 4. Most times (much more than half the time) ❐ 5. Almost always/always	E. Over the past 4 weeks, during sexual intercourse, how often difficult was it to maintain your erection to completion of intercourse? 1. Extremely difficult ❐ 2.Very difficult ❐ 3. Difficult ❐ 4.Slightly difficult ❐ 5. Not difficult ❐
C. Over the past 4 weeks, when you attempted intercourse, how often were you able to penetrate (enter) your partner? 1. Almost never/never ❐ 2. A few times (much less than half of the time) ❐ 3. Sometimes (much more than half of the time) ❐ 4. Most times (much more than half the time) ❐ 5. Almost always/always ❐	F. Over the past 4 weeks, how did you rate your confidence that you could get and keep your erection? 1. Very low ❐ 2.Low ❐ 3.Moderate ❐ 4. High ❐ 5. Very high ❐

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INTERNATIONAL PROSTATE SCORE

Men only questions for men above 50 years. It is about prostate. Leave this section if you wish, tick here❐. If you are over 50, try and fill this section.

Please read the statements and choose which score represents the symptoms you experience. Write your score in the right column.

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	YOUR SCORE
INTERMITTENCY Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
WEAK STREAM Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
STRAINING Over the past month how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
INCOMPLETE EMPTYING Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5	
FREQUENCY Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
URGENCY Over the last month, how difficult have you found to postpone urination?	0	1	2	3	4	5	

	NONE	1 TIME	2 TIMES	3 TIMES	4 TIMES	5 TIMES	YOUR SCORE
NOCTURIA Over the past month, how many times did you most typically get up to urinate from the time you went to bed until the time you got up in the morning?	0	1	2	3	4	5	

TOTAL IPS SCORE

0-7 Mildly symptomatic;
8-19 moderate symptomatic;
20-35 severely symptomatic.

	Delighted	Pleased	Mostly satisfied	Mixed – equally satisfied & dissatisfied	Mostly dissatisfied	Unhappy	Terrible
Quality of life due to urinary symptoms If you were to spend the rest of your life with you urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Your score for "quality of life" question should not be added into your total IPS score

Men sex matters: If you do not wish to answer these questions about sex, tick here ❒ and go to the next section. If you have no problem in your sexual function tick here ❒

MEN: Premature Ejaculation (PE) Assessment

1. When you have sex do you ejaculate too soon (rather than failing to get or maintain an erection)?

No ❒ Yes❒. If yes, proceed. If no, you unlikely have PE. You may have erectile dysfunction – please discuss with a specialist.

2. Have you had this problem since your initial sexual encounters (rather than it being more recent)?

No ❒ Yes ❒. If no, you need to consult a doctor or specialist to assess if you have acquired PE. The treatment is behavioural/psychotherapy, pharmacotherapy medication or combination treatment. If yes, please see specialist to assess severity of PE. Need assessment to establish diagnosis and treatment.

3. Do you have a need to see a doctor about premature ejaculation? No ❒ Yes ❒

4. Would you like us to arrange a clinic appointment with a doctor to discuss this matter? A fee of £99 is payable, instead of £250, for this initial consultation: No ❒ Yes ❒

Together we can help.

K. PATIENT CHOICE

It is important that your GP is fully aware of all your health needs and findings from our clinic. Therefore we are asking an authorization to you in order to send a copy of the report to your GP. Alternatively you may prefer taking a copy of the report with you and give it personally to your GP. We will not be sending a copy of this report to anyone unless you instruct us to do so.

Please let us know your choice by ticking one of the following boxes:

A. I request Medical Express Clinic to send a copy of my report to my GP; details are given below ❒

B. I will take a copy of the report and give it personally to my GP.

For this reason I am not giving my GP's details ❒

C. I wish my GP NOT to know about the present health MOT.

For this reason I am not going to give my GP's details ❒

GP's name (where your report will be sent):

____

Address: ____

____ Postcode: ____________________

If you are under a consultant/specialist state details if you wish us to send a copy of the report

Name of specialist: ____

Address: ____

____ Postcode: ____________________

Do you wish us to send a copy of the report to your specialist? Yes❒ No❒

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L. Healthy Aging Program at Medical Express Clinic.

Now that many of us will live beyond 100 years, we need to age healthy. We need to remain fit. We need to look after ourselves early and check our health state regularly. We need to detect cancers and ill health early. We need to take vitamins and micronutrients. We can check our vitamin state and hormones level which will help to maintain better health balance.

Bone fracture can be prevented by checking for osteoporosis by DEXA scan. Your health check can include calcium score in heart. Your abdominal aorta should be checked for aneurism. This Rupture of Abdominal aortic aneurism is an important, preventable, cause of death. Cervical artery could be checked for narrowly. From 50 years of age have your heart checked by cardiologist including ECG and ECHO every 10 years.

Cancer of bowel should be checked regularly. Ask our nurse.

If you are 50 plus and want to see a doctor with an interest in Healthy AGING, please book an appointment.

If you are overweight and wish to see our experienced doctor to discuss management, book an appointment.

Usual fees: £350. You simply pay £69 today and have discussion about treatment options at Medical Express Clinic. We have two experts doing regular clinic at Medical Express Clinic .

Medical Express is here to help you to have a healthy happy life.

Love all. Serve all.

Putting you first and foremost.

L. ADDITIONAL TESTS AND SERVICES

At Medical Express Clinic while you are having your Health MOT you can request other tests at a reduced price if they are NOT included in the package you have selected.

(1) We can check your body fat content today if this is not part or your Mot package, especially if you are overweight. Fee: £ 5 instead of £30 ❒ (ask the health screening nurse)

(2) ECG Fee: £20 with ECG report from machine – automatic report❒; £60 instead of £110 ❒ (if over 50 years it is good to have a full cardiac tracing once every two years whit consultant cardiologist report. Screening ECG without consultant cardiologist report may not be adequate.)

(3) Chest X-ray Fee: £60 ❒ (to check for tuberculosis and lung cancer; smokers and recent ex-smokers are advised to have an annual chest X-ray; non-smokers once in 5 years or so)

(4) PSA without complex PSA Fee: £45 ❒; PSA profile with complex PSA Fee: £100 ❒

(5) If you have a health problem and wish to have a consultation with a doctor today if this is not part or your MOT package, please tick here Fee: £75 ❒ (please note that this might not be possible if the doctor is busy. This do not apply for Diagnostic Consultations.)

(6) Eye test (visual acuity with distant and near vision assessment and colour vision test) by health screening nurse Fee: £20 ❒

(7) Hearing test with audiogram by health screening nurse Fee: £20 ❒

(8) Cryo-Lipo Therapy. Please ask to nursing staff for more information and fees.

A discount will be given. If interested, please tick here ❒

(9) If you have sleep problem, you may be able to have an assessment with the BOC sleep centre. Please ask the nursing staff. Tick here ❒

(10) Sexual Health Screening. Carrying infections (STI) without knowing is dangerous. It can cause infertility and abortion. It can become pelvic infection, why not to ask to have a check today. Just ask.

(11) HIV test only screening. You are here; we are going to do blood test. Why not have your HIV test done. In London there are many people walking with HIV without knowing they are infected. If HIV is detected it can be treated. Earlier the detection better the results of treatment and AIDS can be prevented by treatment. Usual fee: £110; today you just pay £50(if carried out with other blood test).

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Please write anything else you wish us to consider while doing your MOT. If you are attending for a DIAGNOSTIC CONSULTATION fill the Medical History Questionnaire too. It will be given to you.

____

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Signature:____ Date: _____/___/_______

We will treat all information as strictly confidential.
Information gathered through the present questionnaire will be used only to write your MOT report.
We will use the information to monitor and audit the service we provide.

Thank you for filling the questionnaire

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