VIP Health Promotion Center

Health Screening Questionnaire

Registration No.	
Name	
Date of Birth	
Screening Date	

VIP Health Promotion Center

1. What is your reason for taking health screening?

☐ Regular health screenings (☐ personal ☐ work or group health screening)

☐ Recent health problems

☐ by someone else's recommendation (☐ Family ☐ physician ☐ Others)

2. Marital Status

☐ Single ☐ Married

<In order to implement the safe examination, we would like to ask about your medical history and medication status>

3. Do you know or have any disease diagnosed by a physical examination or by a physician?

○ No

○ Yes.

☐ Stroke
☐ Tuberculosis
☐ Diabetes
☐ Thyroid Disease
☐ malignant (cancer)
☐ Others _____

☐ Arrhythmia
☐ Hepatitis
☐ Asthma
☐ Hyperlipidemia
☐ benign prostatic hyperplasia
☐ psychiatric disorders such as depression

☐ High blood pressure
☐ angina or myocardial infarction
☐ cirrhosis
☐ chronic lung disease
☐ Osteoporosis
☐ urolithiasis

◈ Please answer if you are diagnosed with malignant tumors (cancer) .
What kind of cancer was diagnosed?

4. Have you ever had an allergic reaction of the skin or experienced difficulty in breathing during medical examination in the case of the following?

○ No ○. Yes

☐ After receiving dermatologic treatment or regional anaesthesia
☐ After receiving the contrast medium during MRI, and CT scan
☐ After taking cold or pain medicine
☐ After getting an intravenous injection(IV)
☐ Others

_____

5. Have you ever received any surgery?

○ No ○ Yes

☐ Surgery for cancer treatment indicated by Q3.
☐ Orthopedic surgery due to fractures
☐ Ophthalmic surgery (glaucoma, cataracts, etc.)
☐ ENT surgery (ear, nose, etc.)
☐ back (disk) operation
☐ Others

☐ Appendectomy
☐ Gallbladder Removal
☐ Heart Surgery
☐ artificial joint surgery
☐ transplant surgery
☐ Hysterectomy

6. Are you taking any of the following medicine at the moment?

○ No ○ Yes

☐ Medicine for Allergy
☐ Laxatives
☐ anticoagulants (such as warfarin)
☐ psychiatric medications (depression, etc.)
☐ Thyroid disease treatment
☐ benign prostatic hyperplasia drug

☐ cholesterol drug
☐ Osteoporosis
☐ arrhythmia medicine
☐ blood pressure medicine
☐ hormones
☐ Antituberculosis drug

☐ Diabetes medication, insulin
☐ asthma / chronic airway diseases inhalants
☐ Aspirin
☐ gastric ulcer ,gastritis drug, Acid Reflux
☐ analgesic anti-inflammatory drugs (arthritis medicine, etc.)
☐ Others

◈ **Please answer the question if you are taking anticoagulant(aspirin).**

How many days did you stop taking anticoagulant(Aspirin) for a check-up., if you didn't ,why you did not stop the medicine?

Days : Reasons not to stop the medicine :

<In order to implement the accurate diagnosis and consultation, we would like to ask about your family history.>

7. If anyone of your family members(grandparents, parents, brothers / sisters, children) has diagnosed with any of the following diseases, please check in the boxes.

☐ high blood pressure
☐ Diabetes
☐ stroke
☐ angina or myocardial infarction.

☐ chronic hepatitis / cirrhosis
☐ Hyperlipidemia
☐ Dementia
☐ Cancer
☐ Others _____

<We would like to ask questions regarding your lifestyle, including drink, smoking and exercise.>

8. Please read the questions below and check the box if it is appropriate to your current status.

Smoking

8-1. Have you ever smoked cigarette more than total of 5 packs(100 pieces) in a lifetime?

☐ No (Please go to Q.9) ☐ Yes, but now I have quit. (Please go to Q.8-2)

☐ Yes, and currently smoking (Please go to Q.8-3)

8-2. If you smoked cigarette but now you have quit,

How many years have you smoked before quitting? _____ Years

How many cigarette have you smoked per day?

8-3. If you are currently smoking,

How many years have you been smoking? _____ Years

How many cigarette do you smoke per day?

9. Please read the following questions and check the box if it is appropriate to your current status

Drinking

9-1. How many days do you drink per week?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

9-2. How much do you drink per day? _____Glass

(Calculated in each cup, regardless of the type of drink. However, one can of beer is equal to 1.6 glass)

10. Please read the following questions and check the box if it is appropriate to your recent one week

Exercise

10-1. How many days have you had intense work out more than 20 minutes that makes you breathe much harder than usual for the past 7 days?

(e.g. running, aerobics, cycling in high speed, hiking, etc.)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

10-2. How many days have you had moderate work out more that 30 minutes that makes you breathe little bit harder than usual for the past 7 days?

(e.g. fast walking, playing tennis doubles, cycling in moderate speed, bend down to wipe the floor)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

10-3. How many days have you done walking a total of more than 30 min in a day, including at least 10 minutes of walking at a time, for the past 7 days?

(e.g. light exercise including walking, commuting and leisure time)

Except answers related to Q.10-1.10-2

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

<<The followings are the questions about the symptoms you usually have>

11. These are everyday symptoms, gastrointestinal, cardiovascular, respiratory or urologic symptoms. Please check the boxes.

11-1. General symptoms

☐ fatigue ☐ weight gain ☐ weight loss ☐ cannot stand the hot weather

☐ hot flashes ☐ cold sweat ☐ loss of appetite ☐ cannot stand cold weather

11-2. Gastrointestinal symptoms

☐ indigestion ☐ acid reflux ☐ abdominal pain

☐ dysphagia ☐ changes in bowel habits (frequency or form of stool)

11-3. Cardiovascular / respiratory symptoms

☐ chest pain ☐ lower extremity edema ☐ blood in the sputum

☐ Cough ☐ palpitations ☐ wheezing ☐ shortness of breath during exercise

11-4. Urinary system symptoms

☐ frequent urination ☐ feeling of residual urine after urination ☐ urinary incontinence

☐ nocturia (more than 2 times during sleep) ☐ Discomfort or pain during urination

11-5. Skin, sensory system symptoms

☐ amblyopia (loss of vision) ☐ dry eye ☐ ear pain

☐ Hearing loss ☐ facial flushing ☐ voice changes

☐ Dry skin ☐ neck discomfort ☐ brittle nails

☐ rash (urticaria) ☐ dry mouth ☐ hair loss

☐ blurred vision

11-6. Nervous system, Psychiatric Disorders

☐ Headaches ☐ loss of consciousness ☐ memory deterioration

☐ Depression ☐ dizziness ☐ loss of motivation

11-7. Musculoskeletal symptoms

☐ Joint pain ☐ Joint swelling ☐ joint movement disorders

☐ Muscle pain ☐ muscle weakness ☐ arm, leg cramps

<The following questions are only for female>

14. Are you currently pregnant?

Some tests might affect the fetus, please let us know before the examination.

☐ Yes ☐ No. ☐ not sure.

15. Are there any symptoms present in the breast?

○ If you have symptoms, please check the boxes.

☐ palpable breast mass ☐ Breast pain ☐ lactation (dark red color, milky)

○ If there are symptoms since when?

○ If you have palpable symptoms or mass, where is the location?

☐ left ☐ right

16. Have you ever received a mammogram in the past

○ Yes ○ No

☐ within the last 6 months ☐ 6 months~ 1 year ☐ More than one year

17. Questions relating to menstruation

17-1. When did the menstruation start?

○ Ages :

○ There was no menstruation.

17-2. Are you in menopause? (Menopause means menstruation stopped more than a year)

○ No, I have a regular menstruation

○ I have irregular periods and menstrual bleeding, but not yet menopause.

○ I'm taking hormones cause I have menopausal symptoms.

○ I'm in menopause. (Age :)

☐ It was a natural menopause

☐ due to a hysterectomy (Age :)

☐ due to radiation therapy or drug treatment

18. Please check all if you have any of the symptoms

☐ vulvar itching

☐ Increased vaginal discharge

☐ Pain after a sexual intercourse

☐ Other

☐ irregular menstruation

☐ Cramps

☐ Bleeding after sexual intercourse