Medical Screening Questionnaire

Study: Sympathetic Cerebrovascular Reactivity

Participant Number: ☐

○ FEMALE ○ MALE

Date of Birth (DD/MM/YY): ☐ Age at entry into study: ☐

Occupation: ☐ Marital Status: ☐

Height: ☐ Weight: ☐

Family/Self History (Includes yourself and your immediate family)

DISEASE	RELATIONSHIP TO YOU
☒ Example	Self, daughter, brother, mother, paternal grandmother
☐ Heart Disease	
☐ Neuropathy	
☐ Arthritis	
☐ Orthostatic Hypotension	
☐ Aneurysm	
☐ High Blood Pressure	
☐ Diabetes Type I/ Type II	
☐ Cancer	
☐ Stroke	
☐ Vascular Dementia	
☐ Fibromyalgia	
☐ Allergies	
☐ Alzheimer's Disease	
☐ Seizure	

Ethnic Background

- ☐ Anglo-Australian
- ☐ Aboriginal or Torres Strait Islander
- ☐ Middle Eastern
- ☐ South Asian
- ☐ East and South-East Asian
- ☐ European
- ☐ Pacific Islander
- ☐ African
- ☐ Latin, Central and South American
- ☐ Central Asian
- ☐ Mixed Ethnicity
- ☐ Not Listed(Please specify: ☐)

Nicotine Use (if yes define amount) ○ Y ○ N

I consume Nicotine: ○ Daily ○ Weekly ○ Monthly ○ Yearly

☐ Vaping

☐ Smoking

☐ Other Please specify:

Alcohol (if yes define amount) ○ Y ○ N

I consume alcohol: ○ Daily ○ Weekly ○ Monthly ○ Yearly

Standard drinks per sitting: ○ 1 or 2 ○ 3 or 4 ○ 5 or 6 ○ 6 to 8 ○ More than

Caffeine (Coffee/Energy Drinks)…….. ○ Y ○ N

Recreational Drug Use……..…… ○ Y ○ N

Regular Exercise……..…..Please specify: ○ Y ○ N

Diet ……..Please specify: ○ Y ○ N

Additional History

Have you ever suffered from head trauma?..…… ○ Y ○ N

Have you ever suffered from a concussion?..... ○ Y ○ N

Do you have a history of dizziness? …….. ○ Y ○ N

Have you ever been diagnosed with a vestibular disorder? …….. ○ Y ○ N

If **Yes**, specify

Have you ever been diagnosed with an autonomic disorder?.....… ○ Y ○ N

If **Yes**, specify

Medications

		Name of Medication	Date Started (DD/MM/YY)	Reason for Medication
1.	1			
2.	2			
3.	3			
4.	4			
5.	5			
6.	6			
7.	7			

Supplements (vitamins, nutritional supplements, over the counter medications)

	Name of Supplement	Date Started (DD/MM/YY)	Reason for Supplement
1.			
2.			
3			
4.			
5.			
6.			

Review of Systems (Please explain any Yes response on the line provided)

Head/Neck:

◯ Y ◯ N	Headaches	
◯ Y ◯ N	Change in vision or hearing	
◯ Y ◯ N	Dental/Gums	
◯ Y ◯ N	Abnormal lymph nodes	
◯ Y ◯ N	Trouble swallowing	
◯ Y ◯ N	Retinopathy	
◯ Y ◯ N	Glaucoma	
	Last eye exam	
◯ Y ◯ N	Frequent sore throats	

Cardiovascular:

◯ Y ◯ N	High/Low blood pressure	
◯ Y ◯ N	Chest pain	
◯ Y ◯ N	Heart attack	
◯ Y ◯ N	Coronary Artery Disease	
◯ Y ◯ N	Irregular heartbeat	
◯ Y ◯ N	Palpitations	
◯ Y ◯ N	Leg/ankle swelling	
◯ Y ◯ N	Stroke	
◯ Y ◯ N	Heart murmur	
◯ Y ◯ N	Peripheral Vascular Disease	
◯ Y ◯ N	Cramps in legs:	
	When walking	
	At night	

Respiratory:

◯ Y ◯ N	Asthma	
◯ Y ◯ N	Lung disease	
◯ Y ◯ N	Shortness of breath	
◯ Y ◯ N	Bronchitis	
◯ Y ◯ N	Bloody sputum	
	Last chest X-Ray	

Gastrointestinal:

◯ Y ◯ N	Heartburn	
◯ Y ◯ N	Ulcer disease	
◯ Y ◯ N	Nausea/vomiting	
◯ Y ◯ N	Intestinal disease	
◯ Y ◯ N	Abdominal pain	
◯ Y ◯ N	Constipation	
◯ Y ◯ N	Diarrhoea	
◯ Y ◯ N	Gastroparesis (weak stomach)	
◯ Y ◯ N	Milk intolerance	
◯ Y ◯ N	Egg intolerance	
◯ Y ◯ N	Hepatitis	
◯ Y ◯ N	Liver disease	
◯ Y ◯ N	Gall bladder disease	
◯ Y ◯ N	Bloody stools	
◯ Y ◯ N	Anaemia	
◯ Y ◯ N	Malnutrition	
◯ Y ◯ N	Dehydration	

Genitourinary:

◯ Y ◯ N	Kidney disease	
◯ Y ◯ N	Protein in urine	
◯ Y ◯ N	Urinary Tract Infections	
◯ Y ◯ N	Blood in urine	
◯ Y ◯ N	Kidney stones	
◯ Y ◯ N	Prostate enlargement	

For women only:

Last menstrual period:	
Birth control:	
# of childbirths:	
Start of menopause:	

Neuro/Psyche:

◯ Y ◯ N	Dizziness	
◯ Y ◯ N	Light-headedness	
◯ Y ◯ N	Seizures	
◯ Y ◯ N	Fainting	
◯ Y ◯ N	Loss of consciousness/Concussion	
◯ Y ◯ N	Neuropathy	
◯ Y ◯ N	Numbness	
◯ Y ◯ N	Tingling	
◯ Y ◯ N	Burning	
◯ Y ◯ N	Pain	
◯ Y ◯ N	Walking disturbance	
◯ Y ◯ N	PTSD	
◯ Y ◯ N	Depression	
◯ Y ◯ N	Other Psychiatric disorders	
◯ Y ◯ N	Altered sleep pattern	

Musculoskeletal:

◯ Y ◯ N	Joint pain/swelling	
◯ Y ◯ N	Arthritis	
◯ Y ◯ N	Weakness in arms/legs	
◯ Y ◯ N	Fatigue:	
	Greater than 6 months	
	After viral Illness	
◯ Y ◯ N	Muscle wasting	
◯ Y ◯ N	Back pain	
◯ Y ◯ N	Gout	
◯ Y ◯ N	Tender points	

Other:

◯ Y ◯ N	Thyroid disorder	
◯ Y ◯ N	Unusual hair growth or loss	
◯ Y ◯ N	Fractures	
◯ Y ◯ N	High arches or clawed feet	
◯ Y ◯ N	Exposure to Toxins	
◯ Y ◯ N	Any other medical conditions?	

Surgical History

◯ Yes ◯ None

If yes, please specify:

1. _____ date (DD/MM/YY): _____
2. _____ date (DD/MM/YY): _____
3. _____ date (DD/MM/YY): _____
4. _____ date (DD/MM/YY): _____
5. _____ date (DD/MM/YY): _____