Health History Questionnaire

All data will be kept strictly confidential and will become part of your medical record

Client Personal Information

Legal Name
Doe John

Date of Birth *
1990-01-01

Biological Gender *
Male

Nationality
Hong Kong

Passport Number *
A12345678

Email Address *
mikealpha@abc.xyz

Contact Number (Mobile)*
+852 8765 4321

Contact Number (Home)
+852 1234 5678

Permanent Address in Singapore
123 Clear Bridge St, Hong Kong

Marital Status *
Married

No. of Children
2

Date of Last Health Screening
2023-12-01

Which Countries Have You Travelled to in the Last 3 Months?
Singapore, Malaysia

Previous Abnormal Screening Results: (if any)
Blood Test - High Cholesterol

How did you hear about us?
Relative Referral

Do you agree to be contacted by email for the latest health news and updates from our medical center?

Yes

Personal Health History

Childhood Illnesses

Doe

Immunizations

Doe

Past Medical History & Dates

Year	Operation Name	Hospital

Other hospitalizations

Year	Reason	Any On-going Treatments

Have you ever received a blood transfusion?

Doe

Drug Current and History (including drugs, OTC drugs, supplements, inhalers, Vape, Smoking)

Drug Name	Dose	Frequency

Allergies to medications

Drug Name	Reaction (e.g: rash, shortness of breath, swollen face)

Personal Safety and Social Habits

Do you have frequent falls or fainting spells or episodes of fits (ellipses)? **Yes**

Do you have chronic vision or hearing loss? **No**

Are you on any tobacco products? Cigarettes, Cigars, Vape, E-cigarettes, etc. **Yes**

Are you on any drug-of-abuse products? K-PoP Vape, Heroin, etc **No**

Family History

High Cholesterol **Yes**

Cardiovascular Disease **Yes**

High Blood Pressure **Yes**

Stroke **Yes**

Breast Cancer **Yes**

Ovarian Cancer **Yes**

Cancers If yes, please specify: **Yes**

Mental Health Problems (e.g: depression, anxiety disorders…) **Yes**

Glaucoma **Yes**

Blood clots (e.g.: embolism) **Yes**

Asthma **Yes**

Diabetes **Yes**

Arthritis and autoimmune diseases (e.g.: SLE - Systemic lupus erythematosus) **Yes**

Others: **Yes**

Health Declarations

For the last 5 days and today, are you feeling healthy and generally well? **Yes**

Have a cold, flu, cough, sore throat, diarrhea or any infection in the last 4 weeks? **Yes**

Have a fever in the last 4 weeks? **Yes**

Have viral infection or prolonged contact with others with viral infection (e.g. dengue, chikungunya, zika, chickenpox, measles, Covid-19, rubella, hand foot & mouth disease, hepatitis)? **Yes**

Have a needle-stick injury that exposed you to someone else's blood, or did you get a tattoo, body piercing, or acupuncture? **Yes**

Received a blood transfusion or plasma-derived products? **Yes**

Had heart, lung, or chronic kidney disease? **Yes**

Had hepatitis or liver disease? **Yes**

Had any form of cancer (please state conditions)? **Yes**

Had any blood disorder (e.g. G6PD, thalassemia)? **Yes**

Had autoimmune diseases? **Yes**

Had malaria, babesiosis, or chagas? **Yes**

Received blood transfusion in UK, Ireland, Mexico, Central or South America? **Yes**

Diagnosed with vCJD, CJD, or familial prion disease (similar to mad cow disease)? **Yes**

Had HIV or sexually transmitted diseases? **Yes**

Rejected for blood donation or had blood donation discarded? **Yes**

Other important health issues to declare: **Please specify**

Client Signature

Date

2024-05-15