Medical Questionnaire

- **Fill in (by patients):**

Please write your name here.	
Please write your address here.	
Please write your age here.	
Please write the name and telephone number of someone we can contact.	

- **Questions by healthcare providers to be answered by patients with 'yes' or 'no':**

	YES	NO
1. Do you feel any pain?		
2. Do you have an acute pain?		
3. Do you have a constant pain?		
4. Have you ever lost consciousness?		
5. Are you short of breath?		
6. Do you have any bleeding?		
7. Do you have a headache?		
8. Do you have a stomach ache?		
9. Do you have any diarrhoea?		
10. Are you constipated?		
11. Have you vomited?		
12. Have you ever suffered from high blood pressure?		
13. Have you ever had operations and/or invasive medical procedures?		
14. Have you ever had heart problems?		

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	YES	NO
15. Do you suffer from diabetes?		
16. Do you suffer from epilepsy?		
17. Do you suffer from asthma?		
18. Are you taking any medication?		
19. Are you allergic to any medication?		
20. Are you pregnant?		

- **Explanations (by healthcare providers):**

1. I am going to examine you.
2. I am going to take your blood pressure.
3. I am going to listen to your chest and examine your breathe.
4. I am going to examine your heart.
5. I am going to give you an injection.
6. I am going to write you a prescription.
7. I am going to prescribe a blood test for you.
8. I am going to prescribe a urine test for you.
9. I am going to prescribe an X-ray for you.
10. You need to stay in hospital.

- **Commands (by healthcare providers):**

1. Open your mouth and say ‘aaa’.
2. Undress from waist up.
3. Undress from waist down.
4. Lie down on the bed.
5. Take a deep breath and hold it for a while.
6. Breathe normally.
7. Do not eat anything.
8. Do not drink anything.

THANKS!