CEO HEALTH®
Ethical Medical Outsourcing

# Pre Screening Medical Questionnaire

## 1 - PERSONAL DETAILS

**First Name**

**Last Name**

**Sex**

**Date of birth (DD/MM/YYYY)**

**Profession**

**Type of industry**

**Skype (if available)**

**Telephone: +(...) ......................**

**Email**

**Address**

**Postal code:**

**Country**

## 2 - PRE-SCREENING MEDICAL QUESTIONNAIRE

The CEO-HEALTH medical check-up program is one single program. The program is adapted to each individual based on age, gender, medical history, family history etc. It is specifically tailored to fit your needs. In every sense, the CEO-HEALTH program is unique.

The pre-screening questionnaire provides us with essential information needed by the medical team to organize your medical check-up. Without accurate preliminary information, important physical examinations and / or tests cannot be scheduled during your check-up.

Your personal information is provided to medical professionals *only*, and thus handled in a strictly confidential manner.

The pre-screening questionnaire takes less than 10 minutes as most of the questions can be answered with YES / NO checks.

## 1 - Family medical history

Is there any known "genetic disease" in your family? Yes No

**If yes, please indicate**

| Diseases | Grand parent(s) | Mother | Father | Sister(s) / brother(s) |
|---|---|---|---|---|
| **Hypertension (high blood pressure)** | Yes No | Yes No | Yes No | Yes No |
| **Diabetes** | Yes No | Yes No | Yes No | Yes No |
| **Heart disease Heart attack** | Yes No | Yes No | Yes No | Yes No |
| **Stroke (cerebro-vascular accident)** | Yes No | Yes No | Yes No | Yes No |
| **Cancer (of any type)** | Yes No Which ones: | Yes No Which ones: | Yes No Which ones: | Yes No Which ones: |
| **Other significant diseases** | | | | |

# 2 - Personal Medical background

**Current weight (in Kg)**

**Height (in m)**

**Current weight (in pounds)**

**Height (in feet)**

## 2.1 Lifestyle

### Physical activity

No or very limited physical activity — Yes No

Practice some physical activity — **Times per week** — **Type of physical activities**

### Alcohol consumption

Drink alcohol — Yes No

If YES:

On exceptional basis *: — Yes No

On regular basis: — Yes No

*means rare occasions, less than 4 times a month and in relatively low quantity / "couple of drinks"

Alcohol consumption: mention the average daily intake of alcoholic drinks in units (1 unit = beer (33cl or half a pint), wine (125ml or US 4oz) liquor / spirit beverages in "drink" (25ml or US 1oz shot)):

**Average daily intake (units per day)**

### Tobacco consumption

Never smoked: — Yes No

"Passive" smoker — Yes No

Did not smoke but exposed to high smoking environment for a long period (years).

**Quantify the number of years of "passive smoking" (years)**

Currently smoke: — Yes No

Mention the average past smoking consumption and the current one:

**Past consumption**

**cigarettes / day** — **cigars / day** — **for (years)**

**Current consumption**

**cigarettes / day** — **cigars / day** — **for (years)**

### Stress level in the work place

"Burn-out syndrome" (executive overstress condition): Yes No **If yes, mention the date (year)**

Personal stress assessment [average daily] **Please rate your current stress level on 0 to 10 scale:**
10 = extremely high stress level

## 2.2 Medical background

### Allergies

Do you have an allergy to food or environmental factors? Yes No **If yes, what type(s)**

Do you have an allergy to medicine ? Yes No **If yes, what type(s)**

**Past medical conditions**

Do you have the following conditions?

**Hypertension:** Yes No **If you know your Blood pressure, please provide: (systolic BP / diastolic BP)**

**Diabetes:** Yes No **If you know your fasting blood glucose, please provide: (mmol / L or mg / dL)**

**High cholesterol:** Yes No **If you know your blood total cholesterol, please provide (mmol / L or mg / dL)**

Have you contracted any serious disease(s) in the past? Yes No **If yes, which ones (and when? month/year)**

Have you undergone any surgery in the past? Yes No **If yes, for what reasons and when?**

### Current (if any) medical condition(s)

Are you currently receiving treatment ? Yes No

**If yes, for which disease?**

**Please indicate your current treatment**

Do you take nutrients / vitamins on a regular basis? Yes No

**If yes, which ones?**

## 2.3 Current symptom(s) or medical complaint(s) past 4 months

Do you have any medical complaint(s) bothering you? Yes No

**If yes, please describe which ones and for how long?**

Have you experienced unusual excessive tiredness? Yes No

**If yes, assess your current fatigue level:**
Normal condition: 0 extremely high fatigue: 10

Weight (past 4 months): is your body weight stable? Yes No

**If no, mention either** **weight loss (Kg)** **or weight gain (Kg)**

Appetite (past 4 months): is your appetite stable? Yes No

**If no, assess your current appetite:**
Normal appetite: 0 extremely low appetite level 10

Energy level: please assess your current energy level on 0 to 10 scale

Very low energy level: 0 extremely high energy level: 10

Sleep quality: please assess your overall sleep quality on 0 to 10 scale

Very poor sleep quality: 0 excellent sleep quality: 10

### Have you ever experienced the following symptoms or signs?

Pain of unknown origin Yes No

Shortness of breath Yes No

Difficulties in walking Yes No

Difficulties in strenuous activities Yes No

Blood in stool, spittle, urine Yes No

Difficulties in urinating Yes No

Skin lesions of any type Yes No

Difficulties in digesting Yes No

Difficulties in bowel movements Yes No

Hearing loss or pain in the ears Yes No

Vision problems, pain, blurred vision Yes No

Dizziness or vertigo Yes No

Marks on the skin which have changed Yes No

Itching or skin lack of sensitivity Yes No

## 2.4 Information related to obstetrics and gynaecology FOR WOMEN ONLY

Number of deliveries:

Date of last Pap smear test (DD/MM/YYYY)

Result: Normal Yes No

Have you had any gynaecological problem in the past? Yes No

Do you have any bleeding between menstruations? Yes No

**Date of last menstruations (first day) (DD/MM/YYYY)**

**Please mention results or bring copy of report**

**If yes, please describe which ones and for how long?**

**If yes, please describe which types and for how long?**

## 3 - Other information

### Hepatitis immunity

Do you wish to have a hepatitis test? Yes No

Do you wish to have immunisation check? Yes No

Do you wish for any specific additional tests? Yes No

**If yes, specify**

### Please mention other medical concern, if any:

## 4 - Miscellaneous

1 set of sports-style clothing are provided.

Please indicate the appropriate size

Size of t-shirt [bust / chest]:

Size of pants [waist]:

### Women

| | XS/P | S | M | L | XL |
|---|---|---|---|---|---|
| Size | 2 | 4-6 | 8-10 | 12-14 | 16 |
| Bust | 32.5 | 33-34.5 | 35-36.5 | 38-39.5 | 41 |
| Waist | 24 | 26-28 | 29.5-31 | 32.5-34 | 35.5 |
| Hip | 35 | 36-37 | 38.5-40 | 41.5-43 | 44.5 |

### Men

| | S | M | L | XL | 2XL |
|---|---|---|---|---|---|
| Chest | 36 - 38 | 39 - 40 | 42- 44 | 46 - 48 | 50 - 52 |
| Waist | 28 - 30 | 32 - 34 | 36 - 38 | 40 - 42 | 44 - 46 |

## 3 - PREFERRED DATE

Enter the preferred date of your medical check-up: **Day 1 (DD/MM/YYYY)**

I have read and I accept the CEO-HEALTH terms and conditions:

**Date (DD/MM/YYYY)**

**SUBMIT**

**Thank you, we will contact you shortly.**

**Mac users**: if the SUBMIT button doesn't work, please save and manually attach the document to an email message to: medical.department@ceo-health.com