QUESTIONNAIRE FOR ELDERLY AND RETIREE

Instructions:

Below are list of questions to as certain your health status.
Kindly give the most appropriate answers to the questions below as the result will be reviewed and implemented in the design of your benefit package.
All information shall be kept confidential.

Bio data:

Surname:_____

Other names:_____

Age :_____ Date of Birth :_____
Sex: Male ( ) Female ( )
Marital Status: (a) Married (b) Single (c) Divorced (d) Widow
No of Spouse(s):_____
No of Children:_____ Ages of all the Children(Separate by commas):_____
Present occupation / business(if any)?_____
When did you retire? (if applicable)_____
Residential address:_____
Office address(if any):_____
Choice of Provider/Health facility:_____

Questions:

Please tick(√) the most appropriate answer, and give a brief comment when required.

1) a.Are you Hypertensive? Yes ( ) No ( )
   b.If yes when were you diagnosed? _____
   c.Do you have a blood pressure measuring Kit(Sphygmomanometer)? Yes ( ) No ( )
2) a.Do you have Diabetes Mellitus? Yes ( ) No ( )
   b.If yes ,when were you diagnosed? _____
   c.Do you have a blood sugar measuring Kit (Glucometer)? Yes ( ) No ( )
3) a.Are you a known Sickle cell disease patient? Yes ( ) No ( )
   b.If no, What is your genotype _____ and blood group_____
4) a.Do you take Alcohol ? yes ( ) No ( )
   b.If yes, for how many years have you been taken Alcohol?_____
   c.How many bottles do you take in a day?_____
5) a.Do you Smoke? Yes ( ) No ( )
   b.If yes, for how many years have you been smoking? _____
   c.What type of “stick” do you smoke?A.Cigar ( )B.Cigarette ( )C.Tobacco pipe ( )D. Cannabis( )
   d.How many sticks do you take in a day?_____
6) Do you take kola nut? Yes ( ) No ( )
7) a.Do you have Asthma? Yes ( ) No ( ).b. if yes when were you diagnosed? _____
8) a.Do you have Tuberculosis? Yes ( ) No ( ).b.if yes when were you diagnosed? _____
9) a.Do you have Hepatitis? Yes ( ) No ( ).b. if yes when were you diagnosed? _____
10) a.Do you have Cancer (e.g Breast/ Prostate Cancer) ? Yes ( ) No ( ).b.if yes when were you diagnosed?_____
11) a.Do you have HIV Infection? Yes ( ) No ( ).b.if yes when were you diagnosed? _____
12) a.Do you have any history of Seizures/Epilepsy? Yes ( ) No ( ). b.if yes when were you diagnosed? _____
13) a.Do you have Chronic Skin Disorders? Yes ( ) No ( ).b. if yes when were you diagnosed? _____
14) a.Do you have any history of Heart Diseases Yes ( ) No ( ).b. if yes when were you diagnosed? _____

15) a.Do you have any history of Head Injury/ Severe Accident Yes ( ) No ( ).b. if yes when were you diagnosed?_____
16) a.Do you have any history of Mental Illness? Yes ( ) No ( ).b. if yes when were you diagnosed? _____
17) a.Do you have any history of Allergy?Yes ( ) No ( ).b. if yes what are you allergic to ? _____-
18) a. Do you have any history of Peptic Ulcer Disease ? Yes ( ) No ( ).b. if yes when were you diagnosed? _____
19) a. Are you or your spouse pregnant ?yes ( ) No ( ) **(if applicable)**
b.If yes what is the EDD?_____

20) a.Have you been hospitalized before? Yes ( ) No( ).
b.If yes how many times have been hospitalized? _____
c.Give further details:_____
_____
21) a.Have you had any Surgical Operation in the past. Yes ( ) No ( )
b.If yes ,what was the nature of the Surgery?_____
c.When was it done? _____
22) a.Do you have any genetic disease in your family(e.g Prostate enlargement,Breat lump etc)? Yes ( ) No ( )
b.If yes Kindly state the disease_____

23) a.Do you take any drug(s) regularly? Yes ( ) No ( )
b.If yes ,kindly list the drug(s)_____
24) a.Do You use a wheelchair? Yes ( ) No ( )
b.If yes, Please give the reason for the use of wheel chair_____
25) a.Do you have a nurse taking care of you privately (Home nursing care)? Yes ( ) No ( )
b.If no, Would you subscribe to home care? Yes ( ) No ( )
26) Do you have any other information about your self that you would like us to know?
_____
27) a.Do you or any of your children or relations have any other Pre-existing Medical Condition?
b.If yes give details_____
_____
28) Do you have any other useful information or comments not stated above that may help in the care of the Retiree/Elderly?_____

Declaration:

I declare that any false statement above or non-disclosure of any material fact will render the subscription null and void.

I understand that my membership will be accepted on payment of the subscription fee.

I hereby give permission to Roding Healthcare to have access to any of my medical records.

I hereby accept the terms and conditions of subscription to the Roding Healthcare Benefit package

Signature of principal _____ Date _____/_____/_____

***Please attach a duplicate copy of your international passport/Driver's License/National ID card.**

Thank you.