Questionnaire gezonde-darmflora.nl

Date of birth:
Today's date:
Mobile phone:
Address:

What is your gender?	m/f
What is your weight?	kilo
What is your height?	cm
BMI	cm/kg2

What is your profession/study?	
What is your education level?	
What is your family composition?	
Were you born naturally or by caesarean section?	
Do you have any children?	Yes / No
Have you ever been rejected during an examination (as a donor or otherwise)?	Yes / No
If so, why?	
Have you ever donated blood?	Yes / No
If so when was the last time?	
Have you ever been to a specialist (doctor in the hospital)?	Yes / No
If yes, Date:	
Reason:	
Do you take medicines?	Yes / No
If so, what medications did you receive?	
In what year was this treatment started?	
Have you been depressed in the past?	Yes / No
If so, when did this start and for how long?	
Have you taken any medication for this?	Yes / No
Have you been treated for autism?	Yes / No
Have you ever been tested for diabetes?	Yes / No
If yes, what was the result:	
Does diabetes run in the family?	Yes / No
Is there a family history of schizophrenia/bipolar or anxiety disorders?	Yes / No
Does Creuzfeldt Jakob disease run in your family?	Yes / No
Does dementia run in your family before the age of 60?	Yes / No
Were you born in a country outside Europe or have you lived longer in a country outside Europe for 5 years?	Yes / No
If so where and when?	
Between 1980 and 1996. Are you longer than 6 spent months in the UK?	Yes / No
Do you have an occupational risk of blood-borne infectious diseases? (currently daily patient contact)	Yes / No
If yes, namely?	
Have you ever had a needlestick injury? (for example, an injury with a needle smeared with blood from someone else, or another sharp with blood smeared object?)	Yes / No
Have you ever administered blood products into the bloodstream	

got? (eg blood transfusions)?	Yes / No
If so, when?	
Have you ever injected drugs into your veins (intravenously)?	Yes / No
Have you ever snorted drugs?	Yes / No
Have you ever had a tattoo?	Yes / No
If so, in which country was it placed and when?	
Have you ever had a piercing/earrings done?	Yes / No
If so, in which country was it set?	
Have you ever had acupuncture?	Yes / No
If so in which country?	
Have you ever had growth hormone treatment?	Yes / No
Have you ever had a tissue donation? (eg cornea)	Yes / No
Have you ever had a hair transplant?	Yes / No
Have you ever had surgery or clinical treatment done abroad?	Yes / No
If so, where and when?	
Have you been to the tropics in the past two years?	Yes / No
If so where and which year?	
Have you ever had malaria?	Yes / No
If so in which year?	
Do you also know which type?	Yes / No
Have you ever had special infectious diseases?	Yes / No
If so, which infectious diseases?	
Have you been vaccinated (so no single immunoglobulin injection)	Yes / No
for Hepatitis A?	Yes / No
If so, was the titer sufficient?	
Have you been vaccinated (so no single immunoglobulin injection)	
for Hepatitis B?	Yes / No
If so, was the titer sufficient?	
During a visit abroad (work/vacation) have you ever	
had sexual contact with natives?	Yes / No
Have you had a new sexual partner in the past year?	Yes / No
Have you ever had anonymous sexual contacts?	Yes / No
Have you ever had sexual contact with an intravenous drug user?	Yes No
(for men) Have you ever had sexual contact with a man?	Yes / No
(for women) Have you ever had sexual contact with a bisexual or gay man?	Yes / No
Have you been a recipient of anal sex contact of a new partner in the past year?	Yes / No
Have you ever had sexual contact with someone you paid for with money?	Yes / No
Have you ever had sexual contact with someone who turned out to be infected	
with HIV/HTLV/Hepatitis/Lues?	Yes / No
If so, with what? (to be checked) HIV, Lues, Hepatitis, HTLV, Other, nl:	
Have you ever had a sexually transmitted disease (STD)?	Yes / No
If yes which one?	
Have you ever worked as a prostitute yourself?	Yes / No
Do hereditary diseases run in the family?	Yes / No
If yes which one?	
Do you have a regular stool pattern?	Yes / No
What type of stool do you have? (see attachment/bottom of form!!)	
How many times a day do you have bowel movements on average?	
Do you suffer from excessive flatulence on a daily basis?	Yes / No
Have you ever been treated for an intestinal infection?	Yes / No
If so, how often is this on average per day?	
Have you ever been treated for an intestinal infection?	Yes / No

If yes which one?
When was the last time?
Do you have a chronic bowel disease?
(e.g. Crohn's disease/Ulcerative colitis/Celiac disease)   Yes / No
If yes which one?
Do you ever drink products especially for your bowel movements?
(activities/yakult/actimel etc?)   Yes / No
If so, how often? ... times a day
Do you ever (more than once a month) suffer from difficult bowel movements
(constipation) so that you have to strain for a long time to get the stool out?   Yes / No
If so, how often is this on average per month?
Do you suffer from hemorrhoids?   Yes / No
Do you often have intestinal cramps?   Yes / No
Do you ever take medication to facilitate/slow down bowel movements?   Yes / No
Do you ever take certain foods (plums/fibres) to help with bowel movements?
to ease?   Yes / No
Do bowel disorders run in your family?   Yes / No
If so, which ones and with whom?
Does colon cancer or polyps run in your family?   Yes / No
If so, polyp or colon cancer?
With whom?
At which age?
Have you taken antibiotics in the past three months?   Yes / No
If so, can you remember which antibiotic?
When and how many days?
Have you taken antibiotics in the past year?   Yes / No
for what?
Can you remember which antibiotic? When and for how many days?

Have you ever had rectal bleeding?   Yes / No
If so, has additional research been performed? What were the results of that?

Have you had a fever in the past two weeks?   Yes / No
Have you had diarrhea in the last 3 months   Yes / No
If so, when did it start and how long did it last?
Are there any other things you would like to say or explain?

Type 1
Type 2
Type 3
Type 4
Type 5
Type 6
Type 7