

Questionnaire on general and medical aspects

Please complete this form, save it, and return it by mail to contact@belcolore.be

PART 1: General information

1.1 Last Name:

1.2 First name:

1.3 Date of birth (dd/mm/yyyy)

1.4 Gender

Male

Female

1.5 Country of birth

1.6 Body height

cm

1.7 Body weight

kg

1.8 How many years have you been working
as interventional cardiologist?

years

PART 2 – Medical information

Smoking

2.1 Are you currently a smoker?

No Yes

IF YES

2.1.1 How many cigarettes do you smoke per day?

2.1.2 How many cigars do you smoke per week?

IF NO

2.1.3 Have you smoked in the past?

No Yes

IF YES

2.1.4 When did you stop smoking? In the year

2.1.5 How much did you smoke?

2.1.5.1 Number of cigarettes per day:

2.1.5.2 Number of cigars per week:

Diseases

2.2 Have you ever been diagnosed for one or more of the following diseases?

2.2.1 Diabetes

No Yes

IF YES

2.2.1.1 At what age? years

I can't remember

2.2.1.2 Have you received treatment?

No Yes

IF YES

2.2.1.3 Type of treatment

I can't remember

2.2.2 Hypercholesterolemia

No Yes

IF YES

2.2.2.1 At what age? years

I can't remember

2.2.2.2 Have you received treatment?

No Yes

IF YES

2.2.2.3 Type of treatment

I can't remember

2.2.3 Hypertension

No Yes

IF YES

2.2.3.1 At what age? years

I can't remember

2.2.3.2 Have you received treatment?

No Yes

IF YES

2.2.3.3 Type of treatment

I can't remember

2.2.4 Hyperuricemia

No Yes

IF YES

2.2.4.1 At what age? years

I can't remember

2.2.4.2 Have you received treatment?

No Yes

IF YES

2.2.4.3 Type of treatment

I can't remember

2.2.5 Cancer or other malignant disease

No Yes

IF YES

2.2.5.1 At what age? years

I can't remember

2.2.5.2 Have you received treatment?

No Yes

IF YES

2.2.5.3 Have you received chemotherapy?

No Yes

2.2.5.4 Have you received radiotherapy?

No Yes

IF YES

2.2.5.5 Which part(s) of the body were irradiated

2.3 Have you ever been diagnosed with one of the following eye conditions or diseases?

2.3.1 Cataract

2.3.1.1 Left eye No Yes

2.3.1.2 Right eye No Yes

2.3.2 Glaucoma

2.3.2.1 Left eye No Yes

IF YES

2.3.2.2 Have you received treatment? No Yes

2.3.2.3 Right eye No Yes

IF YES

2.3.2.4 Have you received treatment? No Yes

2.3.3 Age-related macular degeneration

2.3.3.1 Left eye No Yes

IF YES

2.3.3.2 Have you received treatment? No Yes

2.3.3.3 Right eye No Yes

IF YES

2.3.3.4 Have you received treatment? No Yes

2.3.4 Myopia

2.3.4.1 Left eye No Yes

IF YES

2.3.4.2 At what age? Years
I can't remember

2.3.4.3 Right eye No Yes

IF YES

2.3.4.4 At what age? Years
I can't remember

2.3.5 Uveitis

2.3.5.1 Left eye No Yes

IF YES

2.3.5.2 At what age? Years
I can't remember

2.3.5.3 Right eye No Yes

IF YES

2.3.5.4 At what age? Years
I can't remember

2.3.6 When did you have your last appointment with an ophthalmologist?

(month/year)

I can't remember

I never visited an ophthalmologist

2.3.7 Are you wearing glasses?

No Yes

IF YES

2.3.7.1 Since when (year)

2.3.8 Are you wearing contact lenses?

No Yes

IF YES

2.3.8.1 Since when (year)

2.4 Have you ever received treatment for an eye injury or have you had an eye surgery?

2.4.1 Perforating eye injury

2.4.1.1 Left eye

No Yes

IF YES

2.4.1.2 At what age? years

I can't remember

2.4.1.3 Right eye

No Yes

IF YES

2.4.1.4 At what age? years

I can't remember

2.4.2 Eye surgery

2.4.2.1 Left eye

No Yes

IF YES

2.4.2.2 At what age? years

I can't remember

2.4.2.3 What type of surgery? Implantation of artificial lens

Vitrectomy

other:

2.4.2.4 Right eye

No Yes

IF YES

2.4.2.5 At what age? years

I can't remember

2.4.2.6 What type of surgery? Implantation of artificial lens

Vitrectomy

other:

2.5 Have your relatives ever been diagnosed and/or treated with one of the following eye diseases?

2.5.1 Your mother or your father

2.5.1.1 Cataract	No	Yes	I don't know
2.5.1.2 Glaucoma	No	Yes	I don't know
2.5.1.3 Age-related macular degeneration	No	Yes	I don't know
2.5.1.4 congenital blindness	No	Yes	I don't know

2.5.2 One or more of your siblings

2.5.2.1 Do you have siblings?

No Yes

IF YES have they been diagnosed with

2.5.2.2 Cataract	No	Yes	I don't know
2.5.2.3 Glaucoma	No	Yes	I don't know
2.5.2.4 Age-related macular degeneration	No	Yes	I don't know
2.5.2.5 congenital blindness	No	Yes	I don't know

2.5.3 One or more of your biological children

2.5.3.1 Do you have children?

No Yes

IF YES have they been diagnosed with

2.5.3.2 Cataract	No	Yes	I don't know
2.5.3.3 Glaucoma	No	Yes	I don't know
2.5.3.4 Age-related macular degeneration	No	Yes	I don't know
2.5.3.5 Congenital blindness	No	Yes	I don't know

Medications

2.6 Did you ever use systemic steroids?

No Yes I don't know

IF YES

2.6.1 Name of the drug?

I don't know

2.6.2 How did you apply it?

Oral

Inhaled

Into the eye

 2.6.2.1 Left eye

 2.6.2.2 Right eye

Injections (iv/im)

Dermal

2.6.3 How long did you take them in your life altogether?

Less than 1 month weeks

more than 1 month months

I can't remember, but more than 1 month

2.6.4 When did you use steroids for the last time?

(month/year)

I can't remember

Medical radiation

2.7 Have you ever undergone one of the following medical examinations?

2.7.1 CT scan of the head

No Yes I don't know

IF YES

2.7.1.1 How many? (number)

2.7.1.2 When? A1 (year) I can't remember

 A2 (year) I can't remember

 A3 (year) I can't remember

 A4 (year) I can't remember

 A5 (year) I can't remember

 A6 (year) I can't remember

2.7.2 CT scan of the neck

No Yes I don't know

IF YES

2.7.2.1 How many? (number)

2.7.2.2 When? A1 (year) I can't remember

 A2 (year) I can't remember

 A3 (year) I can't remember

 A4 (year) I can't remember

 A5 (year) I can't remember

 A6 (year) I can't remember

2.7.3 PET-CT scan of the head

No Yes I don't know

IF YES

2.7.3.1 How many? (number)

2.7.3.2 When? A1 (year) I can't remember

 A2 (year) I can't remember

 A3 (year) I can't remember

 A4 (year) I can't remember

 A5 (year) I can't remember

 A6 (year) I can't remember

2.7.4 PET-CT scan of the neck

No Yes I don't know

IF YES

2.7.4.1 How many? (number)
2.7.4.2 When? A1 (year) I can't remember
A2 (year) I can't remember
A3 (year) I can't remember
A4 (year) I can't remember
A5 (year) I can't remember
A6 (year) I can't remember

2.7.5 Injected with isotopes for diagnostic or therapeutic purpose?

No Yes I don't know

IF YES

2.7.5.1 How many? (number)
2.7.5.2 When and which type of procedure? A1 (year) I can't remember
B1 Type:
A2 (year) I can't remember
B2 Type:
A3 (year) I can't remember
B3 Type:
A4 (year) I can't remember
B4 Type:

2.7.6 A cerebral angiogram

No Yes I don't know

IF YES

2.7.6.1 How many? (number)
2.7.6.2 When? A1 (year) I can't remember
A2 (year) I can't remember
A3 (year) I can't remember
A4 (year) I can't remember

2.7.7 An interventional radiology/cardiology procedure?

No Yes I don't know

IF YES

2.7.7.1 How many? (number)

2.7.7.2 When and which type of procedure?	A1	(year)	I can't remember
	B1	Type:	
	A2	(year)	I can't remember
	B2	Type:	
	A3	(year)	I can't remember
	B3	Type:	
	A4	(year)	I can't remember
	B4	Type:	

2.7.8 Another kind of medical examination with fluoroscopy to the head?

No Yes I don't know

IF YES

2.7.8.1 How many? (number)

2.7.8.2 When and which type of procedure?	A1	(year)	I can't remember
	B1	Type:	
	A2	(year)	I can't remember
	B2	Type:	
	A3	(year)	I can't remember
	B3	Type:	
	A4	(year)	I can't remember
	B4	Type:	