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: Additional Info Required

IF No: Additional Info Required

Diseases

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

2.2.1 Diabetes

○ No ○ Yes

IF YES: Additional Info Required

2.2.2 Hypercholesterolemia

○ No ○ Yes

IF YES: Additional Info Required

2.2.3 Hypertension

○ No ○ Yes

IF YES: Additional Info Required

2.2.4 Hyperuricemia

○ No ○ Yes

IF YES: Additional Info Required

2.2.5 Cancer or other malignant disease

○ No ○ Yes

IF YES: Additional Info Required

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: Additional Info Required

2.3.2.3 Right eye ○ No ○ Yes

IF YES: Additional Info Required

2.3.3 Age-related macular degeneration

2.3.3.1 Left eye ○ No ○ Yes

IF YES: Additional Info Required

2.3.3.3 Right eye ○ No ○ Yes

IF YES: Additional Info Required

2.3.4 Myopia

2.3.4.1 Left eye ○ No ○ Yes

IF YES: Additional Info Required

2.3.4.3 Right eye ○ No ○ Yes

IF YES: Additional Info Required

2.3.5 Uveitis

2.3.5.1 Left eye ○ No ○ Yes

IF YES: Additional Info Required

2.3.5.3 Right eye ○ No ○ Yes

IF YES: Additional Info Required

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: Additional Info Required

2.3.8 Are you wearing contact lenses?

○ No ○ Yes

IF YES: Additional Info Required

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: Additional Info Required

2.4.1.3 Right eye

○ No ○ Yes

IF YES: Additional Info Required

2.4.2 Eye surgery

2.4.2.1 Left eye

○ No ○ Yes

IF YES: Additional Info Required

2.4.2.4 Right eye

○ No ○ Yes

IF YES: Additional Info Required

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: Additional Info Required

2.5.3 One or more of your biological children

2.5.3.1 Do you have children?

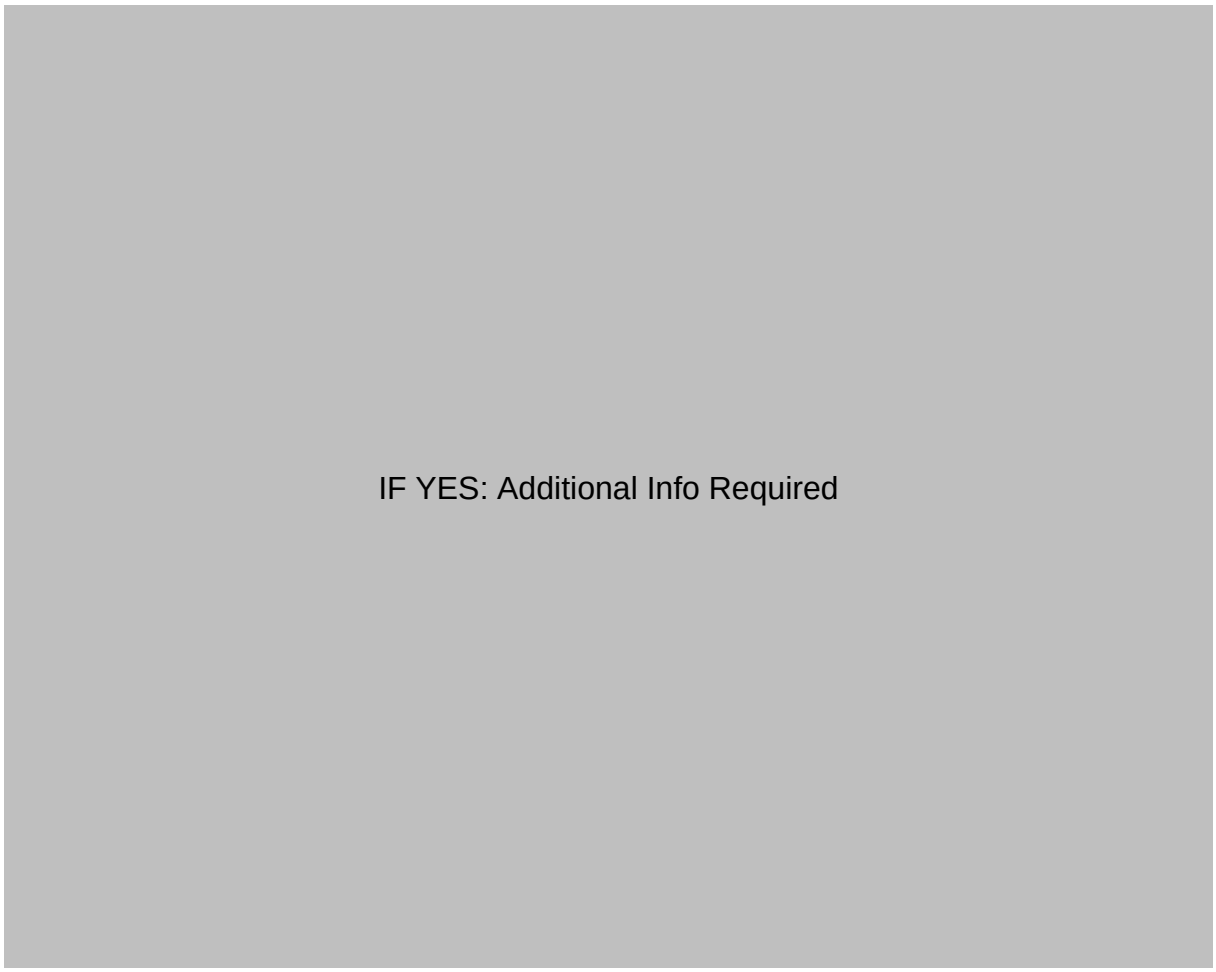
○ No ○ Yes

IF YES: Additional Info Required

Medications

2.6 Did you ever use systemic steroids?

○ No ○ Yes ○ I don't know



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: Additional Info Required

2.7.2 CT scan of the neck

○ No ○ Yes ○ I don't know

IF YES: Additional Info Required

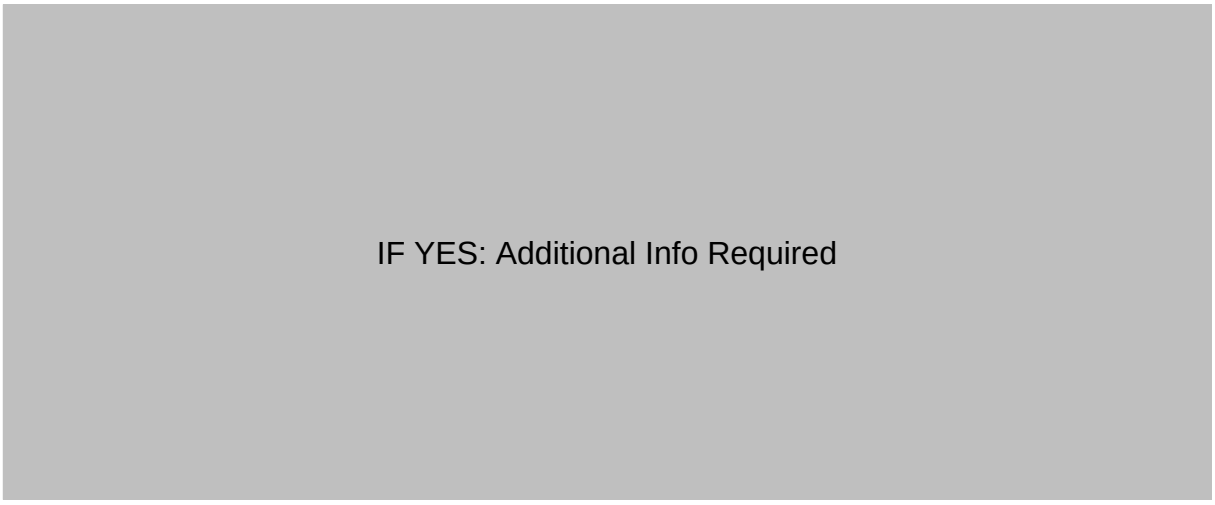
2.7.3 PET-CT scan of the head

○ No ○ Yes ○ I don't know

IF YES: Additional Info Required

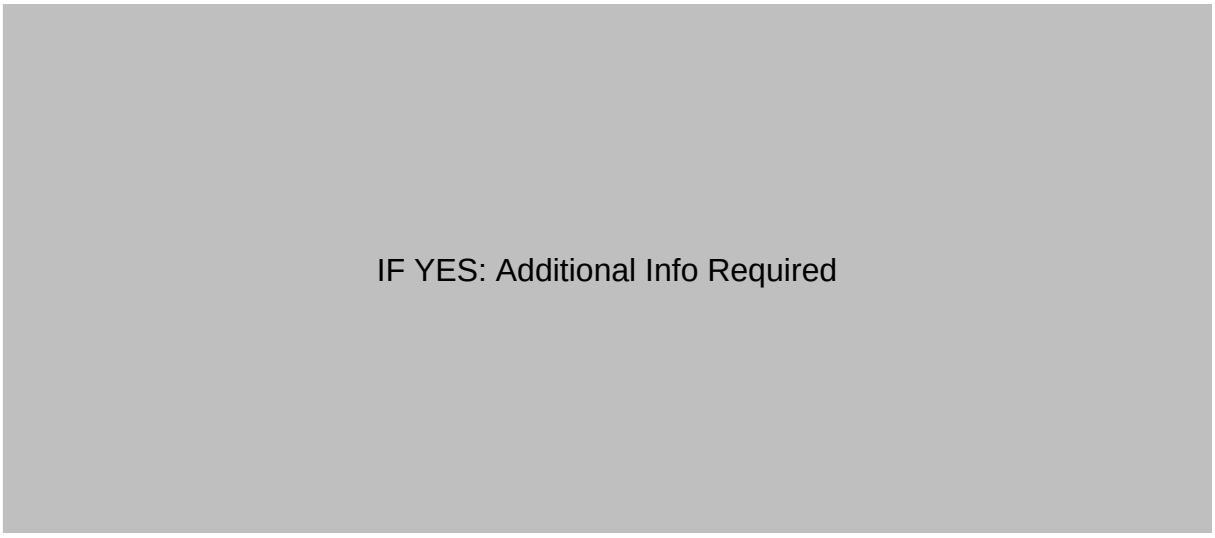
2.7.4 PET-CT scan of the neck

○ No ○ Yes ○ I don't know



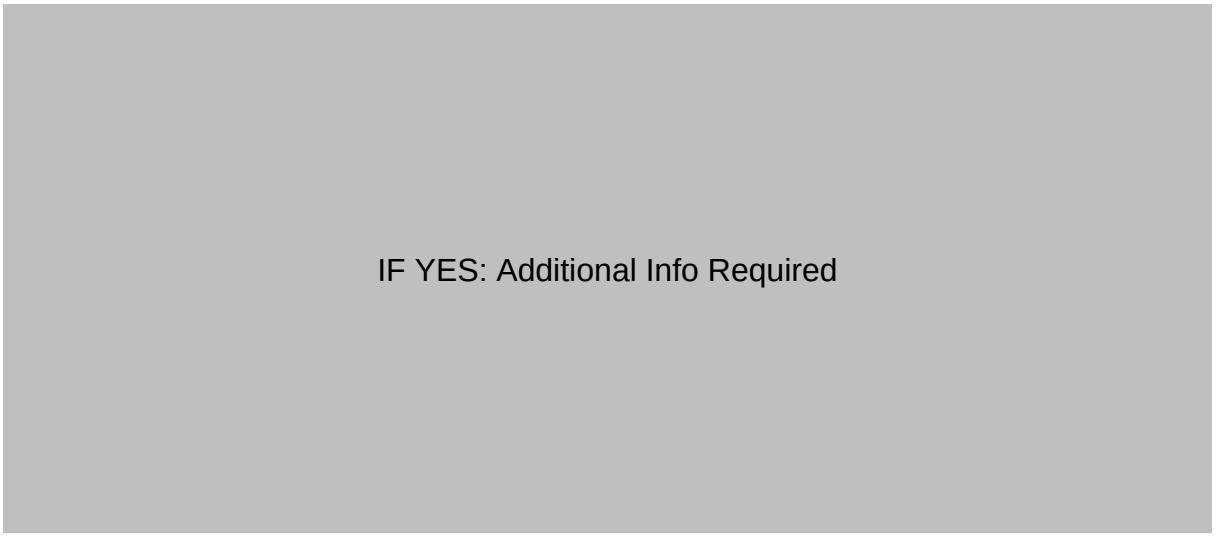
2.7.5 Injected with isotopes for diagnostic or therapeutic purpose?

○ No ○ Yes ○ I don't know



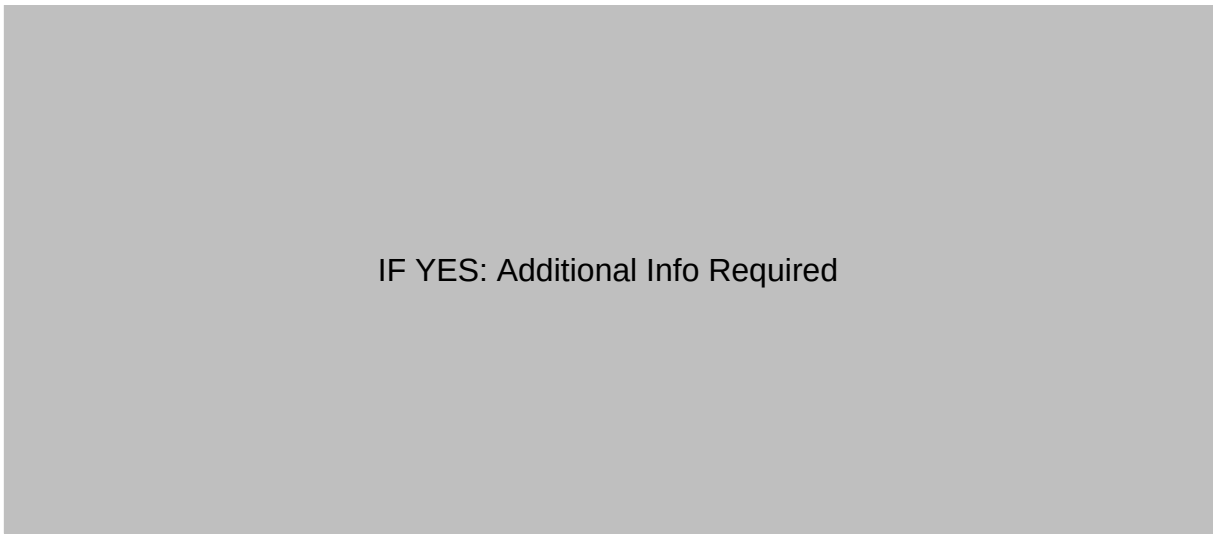
2.7.6 A cerebral angiogram

○ No ○ Yes ○ I don't know



2.7.7 An interventionalradiology/cardiology procedure?

○ No ○ Yes ○ I don't know



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

○ No ○ Yes ○ I don't know