

HEALTH EXAMINATION QUESTIONNAIRE

For third-country nationals from visa-required countries applying for an extension of temporary stay

PRIVACY NOTICE: The information provided in this questionnaire is confidential medical information and will be used solely for the purposes of the medical examination and any necessary diagnostic procedures. Access to the information is restricted to authorised healthcare professionals, in accordance with applicable regulations on the protection of personal data and medical records.

Instructions. Complete the questionnaire legibly and in full. Ask for an interpreter if needed.

A PERSONAL AND EPIDEMIOLOGICAL INFORMATION

First name: _____

OIB: _____

Last name: _____

Date of birth (DD/MM/YYYY): _____

Sex: ☐ Male ☐ Female

Citizenship: _____

Country of birth: _____

Date of first arrival in Croatia: _____

Purpose of stay / occupation in Croatia: _____

Countries visited or transited during the past 12 months, with dates: _____

1. Have you remained continuously in Croatia during the past three months? ☐ YES ☐ NO

If NO, country/countries and travel dates: _____

B CURRENT OR RECENT SYMPTOMS

Current symptoms or symptoms experienced during the past month (select all that apply)

☐ fever

☐ night sweats

☐ persistent cough (2 weeks or longer)

☐ coughing up blood

☐ difficulty breathing

☐ loss of appetite and unexplained weight loss

☐ marked or unusual fatigue

☐ vomiting

☐ swollen glands (lymph nodes) or unexplained lumps

☐ diarrhoea

☐ abdominal pain

☐ blood or mucus in the stool

☐ constipation

☐ jaundice (yellowing of skin or eyes)

☐ worms or worm segments in the stool

☐ pale or clay-coloured stools

☐ dark urine

☐ skin rash

☐ blood in the urine

☐ sudden weakness or paralysis of a limb (hand, leg)

☐ painless genital, anal or oral sore

☐ none of the above

☐ unexplained changes in vision or hearing

Other symptoms: _____

C OTHER RELEVANT MEDICAL HISTORY

1. Do you have any chronic illnesses? ☐ YES ☐ NO

If YES, please specify: _____

2. Do you have any known allergies (medicines, vaccines, food, latex and other)? ☐ YES ☐ NO ☐ DON'T KNOW

If YES, please specify the allergen and the type of reaction: _____

3. Do you have a medical condition or receive treatment that weakens your immune system? ☐ YES ☐ NO ☐ DON'T KNOW

If YES, please specify: _____

4. Do you take any medicines regularly? ☐ YES ☐ NO

If YES, please specify: _____

5. During the past four weeks, have you taken any antibiotics, antimalarial or antiparasitic medicines? ☐ YES ☐ NO

Medicine(s) and dates: _____

6. Are you pregnant or is there a possibility that you may be pregnant? ☐ YES ☐ NO ☐ DON'T KNOW ☐ NOT APPLICABLE

7. Have you been hospitalised during the past 12 months? ☐ YES ☐ NO

If YES, reason, hospital and date: _____

D TUBERCULOSIS HISTORY

1. Have you ever been diagnosed with or treated for tuberculosis? ☐ YES ☐ NO ☐ DON'T KNOW

Year and country of diagnosis: _____ ☐ pulmonary ☐ extrapulmonary ☐ unknown

2. If treated, was the full course of treatment completed? ☐ YES ☐ NO ☐ DON'T KNOW

3. Was drug-resistant tuberculosis ever suspected or confirmed? ☐ YES ☐ NO ☐ DON'T KNOW

4. During the past two years, have you been in close contact with a person with active tuberculosis?

☐ YES ☐ NO ☐ DON'T KNOW

5. Have you ever had a positive tuberculosis test (PPD/TST or IGRA)? ☐ YES ☐ NO ☐ DON'T KNOW

6. Have you had a chest X-ray during the past 12 months? ☐ YES ☐ NO ☐ DON'T KNOW

Date: _____ Country: _____ Report attached: ☐ YES ☐ NO

E TYPHOID AND PARATYPHOID FEVER

1. Have you ever had typhoid or paratyphoid fever? ☐ YES ☐ NO ☐ DON'T KNOW

Year and country: _____

2. Have you ever been identified as a carrier of *Salmonella Typhi* or *Salmonella Paratyphi*? ☐ YES ☐ NO ☐ DON'T KNOW

3. During the past month, have you had persistent high fever, diarrhoea or constipation without a known cause? ☐ YES ☐ NO

F HISTORY OF HIV AND VIRAL HEPATITIS

HIV

1. Have you ever been diagnosed with HIV infection? ☐ YES ☐ NO ☐ DON'T KNOW

Year and country: _____

2. If YES, are you under medical supervision and receiving treatment? ☐ YES ☐ NO

HEPATITIS B

3. Have you ever been diagnosed with hepatitis B? ☐ YES ☐ NO ☐ DON'T KNOW

Year and country: _____

4. If YES, are you under medical supervision or receiving treatment? ☐ YES ☐ NO

HEPATITIS C

5. Have you ever been diagnosed with hepatitis C? ☐ YES ☐ NO ☐ DON'T KNOW

Year and country: _____

6. If YES, have you received treatment for hepatitis C? ☐ YES ☐ NO

7. Was clearance of the infection after treatment confirmed? ☐ YES ☐ NO ☐ DON'T KNOW

G INFORMATION RELEVANT TO ADDITIONAL DIAGNOSTIC TESTING

These questions help the physician determine whether additional tests are indicated.

ENTEROVIRUSES / POLIOMYELITIS

1. During the past three months, have you travelled or stayed outside Croatia? ☐ YES ☐ NO

Country/countries and dates: _____

2. Have you recently had sudden unexplained weakness or paralysis of an arm or leg, difficulty walking, swallowing or breathing? ☐ YES ☐ NO

3. Have you been in contact with a person with confirmed or suspected poliomyelitis or sudden unexplained paralysis?

☐ YES ☐ NO ☐ DON'T KNOW

4. Have you or a member of your household recently received oral polio vaccine (drops/OPV)? ☐ YES ☐ NO ☐ DON'T KNOW

If YES, date if known: _____

HEPATITIS A

1. During the past two months, have you travelled or stayed outside Croatia? ☐ YES ☐ NO

Country/countries and dates: _____

2. During the past two months, have you been in close contact with a person diagnosed with hepatitis A?

☐ YES ☐ NO ☐ DON'T KNOW

MALARIA

1. During or after a stay outside Croatia, have you had fever with chills, shivering, heavy sweating, headache or marked weakness? ☐ YES ☐ NO ☐ DON'T KNOW

2. Have you ever had laboratory-confirmed malaria? ☐ YES ☐ NO ☐ DON'T KNOW

If YES, when and where? _____

3. When did you last leave a country or area where malaria occurs?

Country/area: _____ Date: _____

SCHISTOSOMIASIS (BILHARZIA/SNAIL FEVER)

1. During a stay outside Croatia, did you swim, wade, bathe, wash clothes, fish or work in freshwater such as a river, lake, canal or reservoir? ☐ YES ☐ NO ☐ DON'T KNOW

Country and year of exposure: _____

2. After freshwater exposure, did you have blood in the urine, pain or burning when urinating, blood in the stool or persistent unexplained abdominal symptoms? ☐ YES ☐ NO ☐ DON'T KNOW

3. Have you ever been diagnosed with or treated for schistosomiasis (bilharzia)? ☐ YES ☐ NO ☐ DON'T KNOW

If YES, when, where and with which medicine? _____

SYPHILIS

1. Have you ever been diagnosed with syphilis? ☐ YES ☐ NO ☐ DON'T KNOW

Year and country: _____ Treatment completed: ☐ YES ☐ NO ☐ DON'T KNOW

INTESTINAL PARASITES

1. Have you ever been diagnosed with or treated for intestinal parasites? ☐ YES ☐ NO ☐ DON'T KNOW

If YES, when, where and with which medicine? _____

IMPORTANT: The absence of symptoms does not exclude intestinal parasites, chronic carriage of *Salmonella Typhi/Paratyphi*, latent syphilis, HIV, hepatitis B or hepatitis C.

H MEDICAL RECORDS SUBMITTED

Which of the following results issued during the past 12 months (vaccination from birth) are you submitting?

☐ chest X-ray image and/or report — date: _____ ☐ stool test for *Salmonella Typhi/Paratyphi* — date: _____

☐ anti-HIV test result — date: _____ ☐ HBsAg test result — date: _____

☐ anti-HCV test result — date: _____ ☐ hospital discharge summary or specialist report

☐ other relevant laboratory result(s): _____ ☐ vaccination records for vaccines received during your lifetime (vaccine type, number of doses and dates) – bring any record from birth till this day **only** if you have 35 or less years

☐ none

I DECLARATION AND ASSISTANCE

I declare that I have answered the questions truthfully and to the best of my knowledge. I understand that the examining physician may ask additional questions or recommend further diagnostic procedures.

Date: _____

Applicant's signature: _____

Questionnaire completed: ☐ independently ☐ with an interpreter ☐ with another person

Interpreter/assistant's full name and signature: _____