PERSONAL MEDICAL QUESTIONNAIRE
SPECIFIC PREVENTION

Appointment on ______________________________ at ____________ hr.

Please bring your eID card and vaccination record card.
If you cannot be present on time at the preventive medical examination, please inform us early.

Please bring this completed questionnaire with you to your initial consultation with Group IDEWE and give it to the occupational physician or nurse. This personal questionnaire is **strictly confidential** and is subject to medical confidentiality. It will be filed in your health file.

EMPLOYER'S Administrative details

Employer/company name: ______________________________

IDEWE employer number: ______________________________

EMPLOYEE'S Administrative details: please only fill in the modifications since the previous medical examination

Name: ____________________ First name: ____________________

Address: Street: ____________________ Number and box: ____________________

Postal code: ____________________ Municipality: ____________________

Date of birth: Sex: ☐ Male ☐ Female Nationality: ____________________

Medical Insurance Number: ☐☐☐☐☐☐☐☐☐☐☐

Occupation: ______________________________

Prevention profile: ______________________________

Start of employment: End of employment (if applicable):

Telephone number: ____________________ Mobile number: ____________________

E-mail address (work): ______________________________

Civil status: ☐ single ☐ married ☐ cohabitating ☐ divorced ☐ widow(er)

Health insurance: Name: ____________________ Association number (3 digits): ☐☐☐

Family doctor: Name: ____________________ Telephone number: ____________________

Address: ______________________________

Has the nature of your work changed since your last examination at Groep IDEWE? ☐ yes ☐ no

Explain:

How many hours a week do you work? ______________________________

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Have you had vaccinations since the last examination? Bring your vaccination certificate with you.			
		Vaccination data	Antibody test results
Tedivax (tetanus-diphtheria)	Last vaccination		Not applicable
Boostrix (tetanus-diphtheriapertussis)	Last vaccination		Not applicable
Boostrix - polio (tetanus-diphtheriapertussis-polio)	Last vaccination		Not applicable
Hepatitis B (jaundice)	Min 3 dates		Anti-HBs: IU/L (+ copy lab result)
Hepatitis A (jaundice)	2 dates		
Hepatitis A and B (Twinrix)	3 dates		Anti-HBs: IU/L (+ copy lab result) Antibodies Hep A:
Others, specify:	Last vaccination		

Since your last periodic examination at IDEWE have you suffered from?						
		Yes	No	If so, what diagnosis?	Are you still having problems with this?	Were these problems work-related?
Eyes? (seeing spots, tunnel vision, cataract, glaucoma, etc.)?		☐	☐			
Nose, throat, ears?	Nose?	☐	☐			
	Throat? (e.g. hoarseness, tonsils, etc.)	☐	☐			
	Ears? (e.g. loss of hearing, ear infection, etc.)	☐	☐			
Cardiac or vascular system?	Heart? (e.g. stroke/heart attack, arrhythmias, etc.)	☐	☐			
	Blood pressure?	☐	☐			
	Vascular system? (e.g. varicose veins, piles, etc.)	☐	☐			
Blood? (haemophilia, anaemia, etc.)		☐	☐			

Since the last periodical examination have you suffered from?						
		Yes	No	If so, what diagnosis?	Are you still having problems with this?	Were these problems work-related?
Lungs or respiratory tract? (pneumonia, bronchitis,...)		☐	☐			
Asthma?		☐	☐			
Allergies?	Products? (detergent, nickel, jewellery, etc.)?	☐	☐			
	Hay fever? (pollen, grass, etc.)	☐	☐			
	Latex?	☐	☐			
	Food? (sea food, shell fish, etc.)?	☐	☐			
	Pets? (cats, dogs, etc.)	☐	☐			
	Medication? (penicillin, etc.)?	☐	☐			
Skin? (eczema, psoriasis, warts, etc.)?		☐	☐			
Stomach or intestines? (gastric ulcer, inflammation, reflux, etc.)		☐	☐			
Liver? (jaundice, gall bladder problems, etc.)?		☐	☐			
Kidneys or urinary tract? (kidney stones, bladder infection, etc.)		☐	☐			
Locomotor system?	Skeletal system? (fractures, etc.)	☐	☐			
	Back and neck? (lumbago, herniated disc, blockage, muscle aches, etc.)	☐	☐			
	Systemic disease? (rheumatism, arthritis, etc.)	☐	☐			
	Muscles and/or tendons? (tears, inflammation, tennis elbow, tendinitis, etc.)	☐	☐			
Sexual organs? (ovarian cyst, prostate problems, etc.)		☐	☐			
Nervous system? (burn-out, depression, epilepsy, headache, etc.)?		☐	☐			
Dizziness, fainting?		☐	☐			
Thyroid?		☐	☐			
Diabetes?		☐	☐			
Infectious diseases? (CMV, HIV, glandular fever, etc.)?		☐	☐			
Were you ever involved in an accident?	Accident at home?	☐	☐			
	Accident at work?	☐	☐			
	Needle stick injury?	☐	☐			
	Sports injury?	☐	☐			
	Traffic accident?	☐	☐			
Other complaints?		☐	☐			

Are you in therapy?

Medication - drugs? ☐ Yes ☐ No

If so, please indicate which medication:

Other? (physiotherapist, osteopath, podiatrist, speech therapist, psychologist)? ☐ Yes ☐ No

If so, please indicate which therapy:

For women

Are you pregnant at this moment? ☐ Yes ☐ No

If so, date of last period:

Expected confinement date:

Are you breastfeeding at present? ☐ Yes ☐ No

Smoking habit

☐ Non-smoker ☐ Smoker ☐ Ex-smoker

Smoker: Since: ____________________

Which tobacco product? ____________________ How many? ________ /day

Ex-smoker: Stopped smoking on: ____________________

Aid? ____________________

Physical exercise (in your spare time, and travelling from or to work)?

Which sport(s) do you practise?	For how many minutes (average) per week do you practise it?

Hobbies

Which hobbies do you have?	How many hours (average) per week do you spend on them?

☐ **I have further work-related questions and/or problems which are not specified above, for which I would like to speak to the occupational industrial health officer.**

☐ I hereby declare that I have completed this questionnaire truthfully to the best of my knowledge.

Date:

Signature: