# PERSONAL MEDICAL QUESTIONNAIRE
## AT THE FIRST EXAMINATION

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

Name: _____ First name: _____

Address: Street: _____ Number and box: _____

Postal code: _____ Municipality: _____

Date of birth: Sex: ○ Male ○ Female Nationality: _____

Medical Insurance Number: ☐☐☐☐☐☐☐☐☐☐☐☐

Occupation: _____

Prevention profile: _____

Contract type: ○ worker ○ employee ○ temp ○ intern ○ student ○ other

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

Field of study (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: _____

How many hours a week do you work? _____

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**Vaccination and infection details**

If you have an antibody report, please bring these results with you.

If you have a vaccination record card, please give us a copy.

| | | Have you been vaccinated against the following diseases? If so, indicate the vaccination dates. | Did you contract the disease? If so, specify which disease. | Antibody test results |
|---|---|---|---|---|
| Tedivax (tetanus-diphtheria) | Last vaccination | | ○ Yes, ○ No | Not applicable |
| Boostrix (tetanus-diphtheria-pertussis) | Last vaccination | | ○ Yes, ○ No | Not applicable |
| Boostrix - polio (tetanus-diphtheria-pertussis-polio) | Last vaccination | | ○ Yes, ○ No | Not applicable |
| Hepatitis B (jaundice) | Min 3 dates | | ○ Yes ○ No | Anti-HBs: IU/L (+ lab results copy) |
| Hepatitis A (jaundice) | 2 dates | | ○ Yes ○ No | |
| Hepatitis A and B (Twinrix) | 3 dates | | ○ Yes ○ No | Anti-HBs: IU/L (+ lab results copy)) Hep A Antibodies: |
| Rubella (German measles) Measles-mumps | | | ○ Yes, ○ No | Rubella antibodies: Measles antibodies: Mumps antibodies: |
| Varicella (chicken pox) | | | ○ Yes ○ No | |
| Tuberculosis (BCG) | | | ○ Yes ○ No | Not applicable |
| Toxoplasmosis | | Not applicable | ○ Yes ○ No | |
| Cytomegalovirus | | Not applicable | ○ Yes ○ No | |
| Hepatitis C (jaundice) | | Not applicable | ○ Yes ○ No | |

| | | |
|---|---|---|
| Tuberculin skin test | Date: | Result: |

**Personal medical background**

Do you or did you have medical problems (diseases, disorders, lesions or operations) with:

| | | 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.) | | ○ | ○ | | | |
| 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.)? | | ○ | ○ | | | |

Do you or did you have medical problems (diseases, disorders, lesions or operations) with:

| | | Yes | No | If so, what diagnosis? | Are you still having problems with this? | Were these problems work-related? |
|---|---|---|---|---|---|---|
| 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? |
|---|---|
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| | |

**Hobbies?**

| Which hobbies do you have? | How many hours (average) per week do you spend on them? |
|---|---|
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☐ **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:

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