Premed
Uw partner in preventie

FULL NAME: .... COMPANY: ....
DATE OF BIRTH: .... NUMBER OF EMPLOYER: ....
NATIONAL NUMBER: ....

Medical questionnaire

The aim of this questionnaire is to avoid that you do work that may harm your health.
Please note that your answers will be treated strictly confidentially and kept in your medical file.

PREVIOUS OCCUPATIONS

Company	*Function*	*Period*
1.	....	……….....
2.	....	………..
3.	....	………..
4.	....	………..

FAMILY BACKGROUND

Did someone of your family suffer from:
- asthma : ....
- eczema : ....
- hay-fever : ....
- diabetes : ....

PERSONAL QUESTIONNAIRE

Questionnaire	Yes	No	Comment
- Do you smoke or have smoked?			
- Do you or did you play a sport?			
- Do you consume alcohol?			
- Do you use drugs?			
- Do you suffer from congenital conditions?			
- Have you ever had an accident (on your way home, at home, at work)?			
- Do you have a certain degree of disability? If yes, ... %			
SENSORY ORGANS			
- Do you wear glasses or contact lenses?			
- Do you have an eye disease?			
- Have you ever had any problems with your ears (discharge, etc.)?			
- Have you ever worked in very noisy surroundings?			
RESPIRATORY ORGANS			
- Do you often have a cold?			
- Do you often cough?			
- Have you ever suffered from asthma?			
- Have you ever had hay fever?			
- Have you ever suffered from any other lung condition?			

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THYROID GLAND			
- Have you ever had thyroid problems?			
- Do you have diabetes?			
HEART AND BLOOD VESSELS			
- Do you suffer from a heart disease?			
- Do you sometimes feel a tightness in your chest on exertion?			
ABDOMEN			
- Do you have stomach or intestinal complaints?			
- Have you ever had liver trouble (jaundice, gallstones, …)?			
- Do you suffer from kidney or bladder conditions?			
- Have you ever found albumin, sugar or blood in your urine?			
- Are you pregnant?			
NERVOUS SYSTEM			
- Do you suffer from unconsciousness?			
- Do you suffer from dizziness?			
- Do you suffer from epilepsy?			
- Are you seeing (have you ever seen) a psychologist/psychiatrist?			
SKELETAL SYSTEM			
- Do you often suffer from back pain?			
- Do you often have muscular pains or arthritis?			
- Have you had an inguinal hernia?			
SKIN			
- Has your skin ever reacted to certain chemicals or tissues?			
- Have you ever been treated for dermatitis?			
OTHERS			
- Have your ever been hospitalized for any of the above mentioned diseases?			
- Do you regularly take medication? If yes, which?			
- Are you on a diet? If yes, give details.			
- Do you suffer from any other conditions, not yet mentioned?			

VACCINATIONS	**Yes**	**No**
- **Tetanus**	When:	
- **Rubella**	When:	
- **Hepatitis A: name of the vaccine:**	When:	
	1° ---	
	2° ---	
	3° ---	
- **Hepatitis B: name of the vaccine:**	When:	
	1° ---	
	2° ---	
	3° ---	
	Booster vaccine: -----------------------------	
Have you had a blood test to determine whether you have antibodies for hepatitis B?	When: Result:	
Have you had a **tuberculosis test**?	When:	

I declare that I answered the questions above to the best of my knowledge and ability:

DATE: CITY: SIGNATURE :

Form to be completed by the parent(s)/guardian of people younger than 18 years

Vaccination(s) and/or tuberculin skin test can be carried out during the health examination if the results of the risk analysis show that there is a risk at work during the work-placement.

Refusing this test/vaccination(s) can result in the young person not being allowed to complete the work-placement/employment.

The parent(s) or guardian of people younger than 18 years must give their consent before the test/vaccination(s) mentioned below can be executed.

VACCINATION/TEST	Name vaccination	Agree (*)	Do not agree (*)	Reason for objection

(*) thick the applicable answer

I the undersigned, …………………………………., parent/guardian (°) of …………………………………. give permission for my son/daughter (°) ……………. to receive the abovementioned tuberculin test and/or vaccination(s) if the results of the risk analysis show that there may be a risk during the work-placement or at work.

(°) delete what is not applicable

Signature: …………………………………..

Date: …………………………………………...