GESONDHEETS ZENTRUM
FONDATION HÔPITAUX ROBERT SCHUMAN

Patients' Questionnaire *
Service de Médecine préventive

Surname : _____

Maiden name :_____

First name : _____

Address : _____

Zip code : _____ Village : _____

Date of birth : _____ Sex : _____

Nationality : _____

E-mail address : _____

Name and address of the attending physician :

The purpose of this questionnaire is to obtain an impression of your state of health and to inform the doctor about it. Please bring along your shot record, any medical reports or results of significant medical examinations.

Please fill in this questionnaire carefully and send it to med.prev@hopitauxschuman.lu or per fax at the number 28 88 59 74 before you take your appointment.

All of the enclosed information underlies the medical confidentiality.

*) please use block capitals

1.	FAMILY HISTORY	Yes	No
1.1	Has either one of your parents, siblings, suffered from one of the following ailments?	○	○
1.1.a 1.1.b 1.1.c 1.1.d 1.1.e	- Heart attack - Stroke - High blood pressure - Diabetes - Other Which one :	○ ○ ○ ○ ○	○ ○ ○ ○ ○
1.2	Do you know of any cases of sudden death (occurring in the space of a few hours) of a relative (father, mother, brother, sister) under the age of 55, except after a fatal accident?	○	○
1.3	Do you know of any cases of cancer in your family? If yes, please specify the source organ and the family connection (e.g. maternal grandmother had breast cancer, ...) _____	○	○

2.	GENERAL SIGNS	Yes	No
2.1	Do you generally feel in good health?	○	○
2.2	Is your appetite good?	○	○
2.3	Do you sleep well?	○	○
2.4	Do you already feel tired when you wake up in the morning?	○	○
2.5	What is your normal weight? _____ kg Height : _____ cm	○	○
2.6	Have you lost weight during the last 3 months?	○	○
2.7	How many kg? _____	○	○
2.8 2.9 2.10 2.11	Have you noticed : - an inexplicable fatigue ? - a recent tendency to bleed easily ? - any recent painless swellings ? - any skin lesions that do not heal ?	○ ○ ○ ○	○ ○ ○ ○
2.12	Do you take any medication that you buy yourself? (Sleeping pills, tranquillizers, painkillers) Which one?	○	○

3.	PERSONAL CASE HISTORY	Yes	No
3.1	Have you ever been seriously ill?	○	○
3.1.a	- Diagnosis? _____		
	Age _____		
3.1.b	- Diagnosis? _____		
	Age _____		
3.1.c	- Diagnosis? _____		
	Age _____		
3.2	Have you ever been operated ?	○	○
3.2.a	- What organ? _____		
	Age _____		
3.2.b	- What organ? _____		
	Age _____		
3.2.c	- What organ? _____		
	Age _____		
3.3	Have you taken the pill, estrogens?	○	○
	At what age? _____		
	Which product? _____		
3.4	Have you had any recent medical examinations?	○	○
	Last Gynecological Visit/Mammography? _____	○	○
	Urological Examination?_____	○	○
	_____		
	_____		
3.5	Have you ever had any serious accidents?	○	○
	If yes, which one? _____		
	What part of the body? _____		
3.6	Have you ever suffered from a tropical disease?	○	○
	If yes, which one? _____		
3.7	Have you ever had blood transfusions?	○	○
	When? _____		

4.	WORK	Yes	No
4.1	Do you usually work standing up?	○	○
4.2	Is your work physically exhausting?	○	○
4.3	Do you work in noisy surroundings?	○	○
4.4	Do you work in a team?	○	○
4.5	Do you work with toxic materials?	○	○
4.6	Do you work with radioactive materials?	○	○

5.	HABITS	Yes	No
5.1	Do you consume alcohol? What kind? Weekly consumptions? _____ Glasses/Week	○	○
5.2	Do you smoke? At what age did you start? How many cigarettes do you smoke per day?	○	○
5.3	Have you stopped smoking? Since when?	○	○
5.4	Do you practice any strenuous sport? How many times a week? How many minutes per session in a mean?	○	○
5.5	Do you regularly go for a walk? How many km? How many times a week?	○	○
5.6	Do you sunbathe / go to a solarium? How many times a week?	○	○
5.7	Are you eating 5 portions of fruit and vegetables/day?(one portion=a handful) If not, how many portions?	○	○

6.	MEDICAL TREATMENT	Yes	No
6.1	Are you under treatment or are you on a diet because of :	○	○
6.1.a	- the heart / the blood vessels	○	○
6.1.b	- high blood pressure	○	○
6.1.c	- cholesterol	○	○
6.1.d	- overweight	○	○
6.1.e	- uric acid / gout	○	○
6.1.f	- the skin	○	○
6.1.g	- diabetes	○	○
6.1.h	- a digestive ailment	○	○
6.1.i	- any other ailments	○	○
6.2	Are you under any other form of treatment or are you under the care of a doctor? If yes, who and why?	○	○

7.	FUNCTIONAL DISCOMFORTS	Yes	No
7.1	Have you recently suffered from :	○	○
7.1.a	- Fainting / syncope or blackouts?	○	○
7.1.b	- Tremors?	○	○
7.1.c	- Headaches?	○	○
7.1.d	- Sensory disorders?	○	○
7.1.e	- Difficulties while walking or difficulties maintaining your balance?	○	○
7.1.f	- Paralysis?	○	○
7.2	Do you have troubles with your eyesight?	○	○
7.3	Do you cough? When? _____	○	○
7.4	Do you expectorate? When? _____	○	○
7.5	Has your voice been hoarse for more than 3 weeks?	○	○
7.6	Have you noticed any changes in your sense of hearing?	○	○
7.7	Have you recently had any discharge from your ears?	○	○
7.8	Do you suffer from a nasal obstruction?	○	○
7.9	Does your nose bleed?	○	○

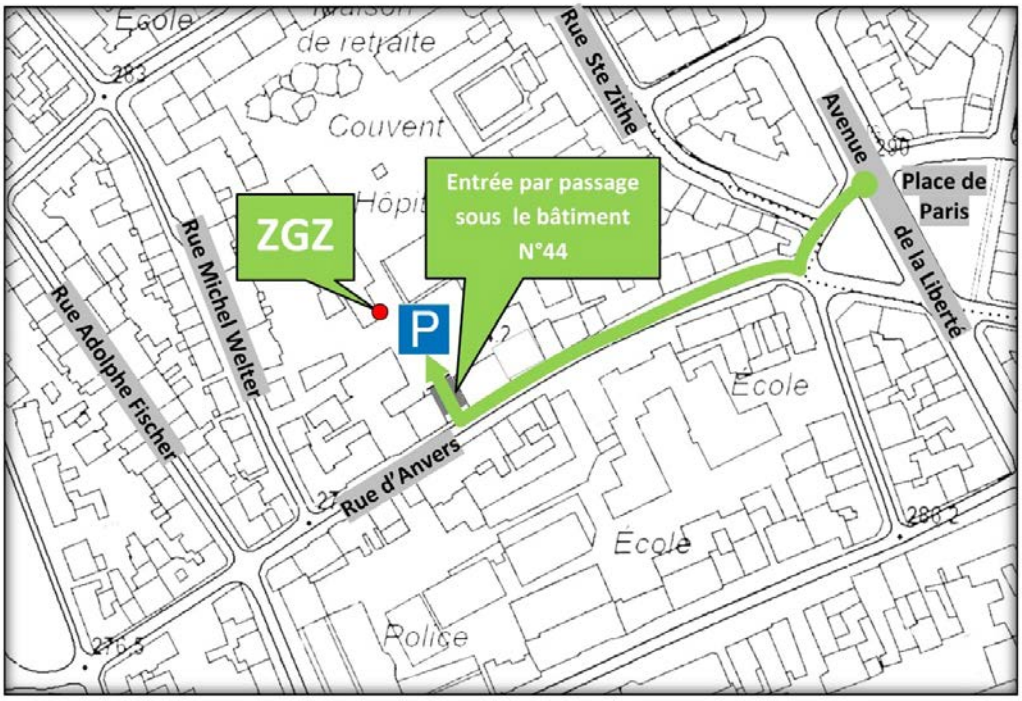
7.10	Are you short of breath :	○	○
7.10.a	- When you are in a hurry?	○	○
7.10.b	- When you're climbing up a slope or stairs?	○	○
7.10.c	- When you are walking in the street at a normal pace with people your age?	○	○
7.11	Do you have pains or discomforts in the chest?	○	○
7.12	Did you ever feel a tight, oppressive pain in the chest? If yes, do you feel that pain or oppression :	○	○
7.12.a	- When you're climbing up a slope or stairs?	○	○
7.12.b	- When you are in a hurry?	○	○
7.12.c	- When you are walking or cycling against the wind?	○	○
7.12.d	- When you are walking normally in the street?	○	○
7.12.e	- When you pass from warm to cold?	○	○
7.12.f	- When you are emotionally agitated?	○	○
7.12.g	- After a meal?	○	○
7.13	Do you feel a pain in your calve(s) when you are walking?	○	○
7.14	Are your ankles or feet swollen in the evening?	○	○
7.15	Are you having difficulties or are you feeling pain while swallowing?	○	○
7.16	Have you lost your appetite?	○	○
7.17	Have you recently felt any aversion to meat?	○	○
7.18	Do you often have stomach aches?	○	○
7.19	Do you vomit often?	○	○
7.20	Have you ever noticed the presence of blood in the vomit?	○	○
7.21	Have you ever noticed the presence of blood in the stools?	○	○
7.22	Have you notices any changes in the stools?	○	○
7.22.a	- In its regularity?	○	○
7.22.b	- In its color?	○	○
7.22.c	- In its consistency (diarrhea)?	○	○
7.23	Are you chronically constipated?	○	○
7.24	Have you noticed :		
7.24.a	- Any difficulties when urinating?	○	○
7.24.b	- A change with the frequency of your need to urinate (day and night)?	○	○
7.24.c	- The presence of blood in the urine?	○	○

8.	**MALE GENITAL ORGANS**		
8.1	Are both testicles present?	○	○
	Do You have to get up at night to urinate? If yes, how many times per night?	○	○

9.	FEMALE GENITAL ORGANS	Yes	No
9.1	**Menstruation**		
9.1.1	At what age did you have your first period? _____ years		
9.1.2	Do you still get your period?	○	○
9.1.3	At what age did your period stop? _____ years		
9.1.4	When was your last period? _____		
9.1.5	Have you noticed any changes with your period?	○	○
9.1.6	Do you bleed in between your period? Since when? _____	○	○
9.1.7	Have you noticed any loss of blood since your menopause?	○	○
9.1.8	Have you noticed any white vaginal discharges? Since when? _____	○	○
9.1.9	Do you suffer from an irritation or pain of the vulva? Explain :	○	○
9.2	**Childbirth**		
9.2.1	Have you ever given birth? How many times? _____ How many miscarriages? _____	○	○
9.2.2	How much did the baby(ies) weigh ? 1 : _____ kg 2 : _____ kg 3 : _____ kg 4 : _____ kg		
9.2.3	Did you suffer from any complications during or after the birth? What kind?	○	○
9.3	**Operations**		
9.3.1	Have you ever had an operation of the genital organs? When? _____ Why?	○	○
9.3.2	Have you ever had a local operation on the cervix (polyps) ? When? _____	○	○
9.3.3	Have you ever used any form of contraception? For how long? _____ What kind? _____	○	○

9.4	**Breasts**		
9.4.1	Have you noticed any hardening of the breast or painful lumps?	○	○
9.4.2	Have you noticed any hardening of the breast or painless lumps?	○	○
9.4.3	Have you ever noticed any discharge from the nipples? clear ☐ bloody ☐	○	○
9.5	**Breast-feeding period**		
9.5.1	Have you breastfed?	○	○
9.5.2	Number of children breastfed : _____		
9.5.3	Average duration of breast-feeding : _____ months		
9.5.4	Did you have an abscess during the breast-feeding period?	○	○
9.5.5	Did you have a surgical treatment for that abscess?	○	○
9.5.6	Did you have a medicinal treatment for that abscess?	○	○

10.	MISCELLANEOUS	Yes	No
10.1	Are you aware of the risks when having unprotected sexual intercourse?	○	○
10.2	Are you aware of the risks of drug addictions?	○	○
10.3	Do you suffer from any complaints or illnesses not covered above? If yes, please give a brief description.	○	○



GesondheetsZentrum : access trough rue d'Anvers no 44 , L-1130