EQUIPE SANTE

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Medical Questionnaire
CONFIDENTIAL

SURNAME – FIRST NAME : . . . .

Gender : □ F □ M □ Other

Date of birth : ....../........./............

Nationality : ....

Address:
street.. Postcode : .... Town : ....

Phone number: .... E-mail address: ....

What faculty are you enrolled in?

- Health Sciences Sector : □ Médecine □ Pharmacie/SBIM □ ESP (Ecole santé publique) □ FSM
- Humain Sciences Sector : □ DROIT □ LSM □ ESPO □ FIAL □ PSP
- Science and Technology Sector : □ TECO □ EPL ou FSP □ AGRO □ Sciences

In which cycle are you enrolled? □ Bac □ Master □ PHD □ Other....................

How do you finance your studies in Belgium?
□ Scholarship □ Support from a guarantor □ Self-funding □ Other......................

What is your family situation? □ Single □ Couple □ With children

Do you have a health care insurance? □ No □ Yes

If so, which one? □ Belgian health insurance □ Private insurance □ Other...................

Family history

* Your father is :

O in good health

O has a serious condition : □ hypertension □ hypercholesterolemia □ diabetes □ other

O dead

* Your mother is :

O in good health

O has a serious condition : □ hypertension □ hypercholesterolemia □ diabetes □ other

O dead

* Other members of the family :

Vaccinations

Please remember to bring you vaccination card or booklet

Give the date of vaccination :

① Tetanus – Diphteria (booster) : .... polio : ....

② Measles-mumps-rubella (MMR) 1st dose : .... 2nd dose : ....

③ Hepatite B or combined vaccination (hepatitis A and B)

1st dose : .... 2nd dose : .... 3ème dose : .... 4ème dose (if relevant) :

⑤ Tuberculosis (BCG) : ....

Lifestyle

What is your weight? ....kg What is your height? ....m

Do you smoke ? O no O yes, every day O yes, occasionally

If yes, ... cigarettes per day

Do you ever user drugs ? O never O occasionally O regularly

Do you drink alcohol ? O yes O no

If yes, do you drink every day ? O yes................ glasses per day

O no, how often : ....

Do you ever drink on your own ? O yes O no

Do you do sport regularly ? O yes O no

If yes, how many hours per week ? ....

Sport(s) : ....

How have you adapted to being at University ? O satisfactorily O unsatisfactorily

Do you have family, friends or neighbours you can turn to if you need help or need to confide in someone ?

O yes O no

Your current state of health

Medical Questionnaire
CONFIDENTIAL

Do you suffer or have ever suffered from

- Respiratory problems (asthma, pneumonia, bronchitis, tuberculosis etc.) O yes O no
  If yes, state which .... Were they treated ? O yes O no

- Ear, nose and throat problems (recurrent sore throats, otitis, sinusitis, deafness, vertigo etc.) O yes O no
  If yes, state which .... Were they treated ? O yes O no

- Cardiac and/or vascular problems (cardiac malformation, arterial hypotension or hypertension, acute rheumatic fever, irregular heartbeats etc.) O yes O no
  If yes, state which .... Were they treated ? O yes O no

- Digestive problems (stomach ache, diarrhoea, vomiting etc.) O yes O no
  If yes, state which .... Were they treated ? O yes O no

- Urino-genital problems (cystitis, kidney stones albuminuria etc.) O yes O no
  If yes, state which .... Were they treated ? O yes O no

- Sexually transmitted diseases O yes O no
  If yes, state which .... Were they treated ? O yes O no

- Vision problems O yes O no
  Corrected by glasses or contact lenses O yes O no
  Date of last visit to optician ....

- Problems with the osteo-articular system O yes O no
  If yes, state which :..

- Skin problems O yes O no
  If yes, state which .... Were they treated ? O yes O no

- Endocrine problems (diabetes, goitre, hypothyroidism or hyperthyroidism) O yes O no
  If yes, state which .... Were they treated ? O yes O no

- Problems relating to blood, lymph nodes, bone marrow (e.g. anaemia, haemorrhage, phlebitis) O yes O no
  If yes, state which .... Were they treated ? O yes O no

- Tropical diseases (e.g. malaria) — O yes O no
  If yes, state which .... Were they treated ? — O yes O no

- Problems of the nervous system (e.g. epilepsy, meningitis, headaches) — O yes O no
  If yes, state which .... Were they treated ? — O yes O no

- Problems of anxiety and/or depression — O yes O no
  Drugs taken ....

Are you currently taking any drugs? — **O yes** **O no**

If yes, state which ones and the amount :

....

....

Have you had any operations? Please give the year

.... in ....

.... in ....

Current state of health

Would you like to talk about any of the following topics with a doctor ? Please circle.

Tobacco Alcohol Illnesses

Food Loneliness

Addictions Unhappiness

Feeling apart Relationships Appetite Sadness

Sleep Pains

Family Stress

The Student Support Office collects, processes and stores personal data solely for the purpose of medical processing of your file. Your data is processed in accordance with applicable legislation on the right to privacy and Regulation 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC. This processing is in the legitimate interests of the Student Support Office. The data we process is never disclosed to third parties. It is stored for the time required to process your file. In accordance with the legislation in force, you have the right to access, rectify and delete your individual data. If you wish to exercise this right, or if you have any questions concerning your data, contact us at the following e-mail address: aide-sante@uclouvain.be. Data controller: Student Support Office – UCLouvain. Address: Florence Vanderstichelen, 10 rue des Wallons - 1348 Louvain-la-Neuve