

MEDICAL QUESTIONNAIRE

To be completed only during your first visit.

The principle of preventive medicine is to attempt to detect health problems early.

Follow-ups, potential additional tests, final diagnosis, and treatment will be carried out by your GP. It is therefore essential to forward a copy of the file you will receive following the examination to your GP.

Please note that no prescriptions for medication or treatment can be requested in preventive medicine.

Name :
First Names :
Gender :
Date of Birth :
Nationality :
Employer :
Profession :
GP (nom et adresse) :

FAMILY HISTORY

When completing the table below, consider the following

Cardiovascular:

- Myocardial infarction / heart attack / sudden death
- Stents or bypass
- Angina
- Arteritis (arterial disease)
- Stroke (CVA, "attack" or thrombosis)
- Hypertension
- Familial hypercholesterolemia

Diabetes:

- Type 1 diabetes (occurs at a young age, requires insulin injections)
- Type 2 diabetes (develops later, treated with oral medication)

Cancer :

- Breast – Uterus/Ovaries - Prostate – Intestines/Colon – Lungs – Stomach – Melanoma/Skin - Other

Glaucoma

Degree of Relation	Illness	Age of Onset
Father		
Mother		
Brother 1		
Brother 2		
Sister 1		
Sister 2		
<i>Maternal Family:</i>		
Grandfather		
Grandmother		
Uncle(s)/Aunt(s)		
<i>Paternal Family:</i>		
Grandfather		
Grandmother		
Uncle(s)/Aunt(s)		

PERSONAL MEDICAL HISTORY

Have you suffered from / or been hospitalised for any condition?	If yes, tick	Year?	Details
Hypercholesterolemia	<input type="checkbox"/>		
Hypertension	<input type="checkbox"/>		
Diabetes	<input type="checkbox"/>		
Cardiac (heart attack, stent, bypass, arrhythmia, valve problem...)	<input type="checkbox"/>		
Vascular (stroke, TIA, arteritis, varicose veins...)	<input type="checkbox"/>		
Pulmonary (asthma, chronic bronchitis, sleep apnoea, polysomnography...)	<input type="checkbox"/>		
Endocrine (diabetes, thyroid...)	<input type="checkbox"/>		
Gastro-intestinal/digestive (stomach, pancreas, peritonitis, intestines, diverticulitis...)	<input type="checkbox"/>		
Hepatic (liver, gallbladder...)	<input type="checkbox"/>		
Kidney	<input type="checkbox"/>		
Urinary (prostate, bladder, kidney stones...)	<input type="checkbox"/>		
Osteoarticular and rheumatologic (fractures, ligament, muscular or joint injuries)	<input type="checkbox"/>		
Neurological (migraine, epilepsy...)	<input type="checkbox"/>		
Ophthalmological (glaucoma, cataract, macula...)	<input type="checkbox"/>		
ENT (ear, nose, throat)	<input type="checkbox"/>		
Haematological/blood disorders (anaemia, iron issues, leukaemia, lymphoma...)	<input type="checkbox"/>		
Coagulation (embolism, thrombosis, phlebitis, haemophilia...)	<input type="checkbox"/>		
Infectious or tropical diseases	<input type="checkbox"/>		
Psychological (burnout, depression, anxiety...)	<input type="checkbox"/>		
Dermatological/skin disorders	<input type="checkbox"/>		
Cancer treatment (chemotherapy, radiotherapy, hormones...)	<input type="checkbox"/>		
Consequences of an injury	<input type="checkbox"/>		
Other :	<input type="checkbox"/>		

PERSONAL SURGICAL HISTORY

<i>Have you had surgery for any condition?</i>	<i>If yes, tick</i>	<i>Year?</i>	<i>Details</i>
Pulmonary	<input type="checkbox"/>		
ENT (ear, nose, throat)	<input type="checkbox"/>		
Cardiovascular (heart, arteries, veins...)	<input type="checkbox"/>		
Neurological	<input type="checkbox"/>		
Gastro-intestinal (appendix, liver, gallbladder, polyps...)	<input type="checkbox"/>		
Renal or urinary (prostate, bladder...)	<input type="checkbox"/>		
Endocrine (thyroid)	<input type="checkbox"/>		
Orthopaedic or traumatic	<input type="checkbox"/>		
Ophthalmological (refractive surgery, cataract, glaucoma...)	<input type="checkbox"/>		
Dental (wisdom teeth, jaw...)	<input type="checkbox"/>		
Congenital malformations	<input type="checkbox"/>		
Other :	<input type="checkbox"/>		

GYNAECOLOGICAL HISTORY

<i>Questions</i>	<i>Answers</i>
Age of first menstruation?	
Number of pregnancies (including miscarriages and terminations)?	
Illness during pregnancy (hypertension, eclampsia, diabetes...)?	
Years of deliveries?	
Breastfeeding for over 3 months?	
Do you use contraception? Pill – Vaginal ring – Implant – Non-hormonal coil – Hormonal coil – Tubal ligation – Condom – Other	
Are your periods painful - heavy - irregular?	
Date of last period?	
Are you going through menopause? Are you experiencing the following symptoms: arthralgia - sleep disturbances - hot flashes - emotional lability?	
Have you taken hormone replacement therapy? For how long?	
Have you suffered from / been hospitalised for / had surgery for any gynaecological or breast condition?	

SCREENING TESTS

Which screening tests have you undergone?	If yes, tick	Year?	Results
Colon Cancer (aged 45+): <ul style="list-style-type: none"> • Colonoscopy? • Blood stool test using colotest (iFobt - hemoccult)? 	<input type="checkbox"/> <input type="checkbox"/>		
Skin Cancer: <ul style="list-style-type: none"> • Skin screening by a dermatologist? 	<input type="checkbox"/>		
Cardiovascular Prevention (aged 45+): <ul style="list-style-type: none"> • Cardiac check-up? • Stress test? 	<input type="checkbox"/> <input type="checkbox"/>		
Lung Cancer (smokers and ex-smokers aged 50+): <ul style="list-style-type: none"> • Pulmonary function test by a pulmonologist? • Lung scan? 	<input type="checkbox"/> <input type="checkbox"/>		
Glaucoma (40 ans+) : <ul style="list-style-type: none"> • Eye pressure test by an ophthalmologist? 	<input type="checkbox"/>		
Dental Check-up?	<input type="checkbox"/>		
For Women:			
Cervical Cancer: <ul style="list-style-type: none"> • Gynaecological smear test? • HPV test? 	<input type="checkbox"/> <input type="checkbox"/>		
Breast Cancer (aged 40+): <ul style="list-style-type: none"> • Mammogram? • Breast palpation? 	<input type="checkbox"/> <input type="checkbox"/>		
Osteoporosis (post-menopause): <ul style="list-style-type: none"> • Bone density scan? 	<input type="checkbox"/>		
For Men:			
Prostate Cancer (aged 50+): <ul style="list-style-type: none"> • PSA test? • Urological exam? (with ultrasound or MRI) 	<input type="checkbox"/> <input type="checkbox"/>		

ALLERGIES - INTOLERANCES

Are you prone to any of the following allergies/intolerances?	If yes, tick
Intolerance :	<input type="checkbox"/>
• Lactose	<input type="checkbox"/>
• Gluten	<input type="checkbox"/>
• Have you undergone a test to confirm this intolerance?	<input type="checkbox"/>
Allergy :	<input type="checkbox"/>
• Medication	<input type="checkbox"/>
• Food	<input type="checkbox"/>
• Respiratory / Allergic Rhinitis ("hay fever")	<input type="checkbox"/>
• Skin (insect bites, eczema, hives)	<input type="checkbox"/>
• Quincke's oedema / Anaphylactic shock	<input type="checkbox"/>
• Have you undergone skin or blood allergy tests?	<input type="checkbox"/>

MEDICATIONS AND TREATMENTS

What medications do you take regularly?

Name	Dose (mg)	Number of doses per day	Since when ?

What medications do you take occasionally?

Name	Dose (mg)	Number of doses per day	Since when ?

Specifically consider:

- Sleeping pills – Tranquilisers – Antidepressants?
- Antihypertensives – Anticoagulants – Heart medications – Cholesterol – Diabetes?
- Contraception? Menopause treatment?
- Eye drops?
- Creams?

<i>Other types of treatments:</i>	<i>If yes, tick</i>
CPAP or sleep apnoea treatment	<input type="checkbox"/>
Hearing aids	<input type="checkbox"/>
Compression stockings – Orthopaedic insoles	<input type="checkbox"/>
Physiotherapy – Osteopathy	<input type="checkbox"/>
Psychotherapy	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>

VACCINATIONS

Please bring your vaccination card if possible

<i>Type</i>	<i>Date of last dose</i>	<i>Total doses</i>
Tetanus, Diphtheria, Pertussis (1x/10 years)		
Poliomyelitis		
Influenza (aged 65+)		
Pneumococcus (aged 65+)		
COVID (aged 65+)		
Shingles (aged 65+)		
Hepatitis A		
Hepatitis B		
Yellow Fever		
Measles, Rubella, Mumps		
HPV		
Other: Meningitis ACWY, Typhoid fever, Rabies, FSME, Tick-borne Encephalitis		

LIFESTYLE HABITS

Questions	If yes, tick	Details / Answers
Smoking :		
<ul style="list-style-type: none"> • You have never smoked 	<input type="checkbox"/>	
<ul style="list-style-type: none"> • You stopped smoking in (year) <ul style="list-style-type: none"> ○ You smoked for ... years ○ How many per day? 	<input type="checkbox"/>	
<ul style="list-style-type: none"> • Do you currently smoke: <ul style="list-style-type: none"> ○ Cigarettes – Cigars/Cigarillos – Pipe – Rolling tobacco – Cannabis – E-cigarettes/vaping ○ How many per day? ○ For how many years? ○ Have you ever quit smoking? ○ Do you intend to quit smoking? ○ When do you smoke your first cigarette after waking up? <ul style="list-style-type: none"> ▪ 5 min – 30 min – 60 min - >60 min 	<input type="checkbox"/>	
Do you consume drugs or narcotics?	<input type="checkbox"/>	
Physical Activities:		
<ul style="list-style-type: none"> • How many times a week do you engage in at least: <ul style="list-style-type: none"> ○ 30 minutes of moderate physical activity (walking, cycling, dancing, yoga, gardening)? ○ 25 minutes of intense physical activity (fitness, running, tennis, football, intense cycling)? • Which activities? 		
Diet :		
<ul style="list-style-type: none"> • Do you follow a specific diet? <ul style="list-style-type: none"> ○ Lactose-free / Gluten-free ○ Low salt / sugar / cholesterol ○ Vegetarian / Vegan 	<input type="checkbox"/>	
<ul style="list-style-type: none"> • Do you have a daily source of calcium? <ul style="list-style-type: none"> ○ Dairy products ○ Green vegetables ○ Almonds and nuts ○ Plant-based milks (almond milk, soya milk, rice milk...) ○ Calcium-rich water (e.g., Hepar, Contrex, San Pellegrino) 	<input type="checkbox"/>	
<ul style="list-style-type: none"> • How many portions of 100g of fruits and/or vegetables do you consume per day? (100g = approx. one apple or carrot) 		

LIFESTYLE HABITS - CONTINUED

Questions	If yes, tick	Details / Answers
Diet – Continued :		
<ul style="list-style-type: none"> • How often per week do you consume: <ul style="list-style-type: none"> ○ Red meat or equivalent (minced, pork, charcuterie...)? ○ White meat – Poultry- Fish – Shellfish – Seafood– Eggs? ○ Plant-based proteins (legumes, tofu, quinoa...)? ○ Whole grains – Seeds 		
<ul style="list-style-type: none"> • What is your daily fluid intake (in litres)? <ul style="list-style-type: none"> ○ Water ○ Sodas and juices ○ Coffee – Tea – Coca-Cola – Energy drinks ○ Other (soups, milk...)? 		
<ul style="list-style-type: none"> • Alcoholic beverages (1 unit = 25cl beer, 10cl wine, 2.5cl spirit at 40°): <ul style="list-style-type: none"> ○ Do you consume more than 10 units per week? ○ Do you observe at least 2 alcohol-free days per week? ○ How often do you drink more than 2 units per day? 	<input type="checkbox"/> <input type="checkbox"/>	

1 Standard Drink contains 10g of pure alcohol



<https://healthwell.eani.org.uk/healthtopic/alcohol-guidance/how-much-am-i-drinking>

CURRENT HEALTH PROBLEMS

CARDIOCIRCULATORY AND RESPIRATORY SYSTEM

Questions	If yes, tick	Details
Tightness or pain in the chest (at rest – during exertion – under stress)?	<input type="checkbox"/>	
Shortness of breath (at rest or during exertion)?	<input type="checkbox"/>	
Palpitations?	<input type="checkbox"/>	
Cough?	<input type="checkbox"/>	
Phlegm? Colour?	<input type="checkbox"/>	
Hoarseness or voice roughness?	<input type="checkbox"/>	
Pain in the legs while walking? After how far?	<input type="checkbox"/>	

DIGESTIVE SYSTEM

Questions	If yes, tick	Details
Change in bowel movement frequency?	<input type="checkbox"/>	
Diarrhoea?	<input type="checkbox"/>	
Constipation?	<input type="checkbox"/>	
Acid reflux ("heartburn")? How often?	<input type="checkbox"/>	
Blood in stools or after passing stools?	<input type="checkbox"/>	
Recent weight change? How many kg and over how long?	<input type="checkbox"/>	

MUSCULOSKELETAL SYSTEM

Questions	If yes, tick	Details
Do you experience back pain? Upper – Middle – Lower back?	<input type="checkbox"/>	
Other joint pain?	<input type="checkbox"/>	
Swollen joints? Which ones?	<input type="checkbox"/>	
Have you undergone examinations for these pains (X-ray, scan, MRI, ultrasound)?	<input type="checkbox"/>	

UROGENITAL SYSTEM

<i>Have you noticed:</i>	<i>If yes, tick</i>	<i>Details</i>
<ul style="list-style-type: none"> Blood in urine? Urine leakage during exertion – coughing – laughing? How many times per night do you wake to urinate? Are you experiencing symptoms of prostatism: decreased stream strength, incomplete bladder emptying? Does this affect your quality of life? 	<input type="checkbox"/> <input type="checkbox"/>	

NEUROLOGICAL SYSTEM

<i>Questions</i>	<i>If yes, tick</i>	<i>Details</i>
Do you experience unexplained loss of consciousness?	<input type="checkbox"/>	
Do you experience headaches? <ul style="list-style-type: none"> Frequency (per day – week – month)? Recent occurrence or chronic issue? 	<input type="checkbox"/> <input type="checkbox"/>	

ENT (Ear, Nose, and Throat)

<i>Questions</i>	<i>If yes, tick</i>	<i>Details</i>
Do you experience tinnitus? <ul style="list-style-type: none"> How long? Have you undergone evaluation for tinnitus? 	<input type="checkbox"/>	
Have you noticed hearing problems?	<input type="checkbox"/>	

DERMATOLOGY

<i>Questions</i>	<i>If yes, tick</i>	<i>Details</i>
Are you regularly monitored by a dermatologist? How often?	<input type="checkbox"/>	
Experiencing skin problems?	<input type="checkbox"/>	
Noticing a birthmark or mole that has appeared or recently changed?	<input type="checkbox"/>	
Prone to rashes or itching?	<input type="checkbox"/>	

HEMATO IMMUNE SYSTEM

<i>Questions</i>	<i>If yes, tick</i>	<i>Details</i>
Have you ever had an iron deficiency or anemia?	<input type="checkbox"/>	
Do you have a coagulation problem?	<input type="checkbox"/>	

OPHTHALMOLOGY

Questions	If yes, tick	Details
Are you suffering from <ul style="list-style-type: none"> • Myopia (problem seeing far away) • Hyperopia (problem seeing up close) • Presbyopia (problem seeing up close after age 40) 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Do you have an eye disease?	<input type="checkbox"/>	
Do you have known and/or treated intraocular hypertension or glaucoma?	<input type="checkbox"/>	

SLEEP

Questions	If yes, tick	Details
Do you suffer from sleep disorders? <ul style="list-style-type: none"> • Difficulty falling asleep • Difficulty staying asleep (frequent nocturnal awakenings, early waking) • Do you suffer from daytime sleepiness? 	<input type="checkbox"/> <input type="checkbox"/>	

PROFESSIONAL AND/OR PRIVATE STRESS

Questions	If yes, tick	Details
Source of stress: <ul style="list-style-type: none"> • Work-related due to workload • Work-related due to relationships with colleagues • Personal 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Do you feel that your current stress level is under control?	<input type="checkbox"/>	
Do you feel that your stress affects: <ul style="list-style-type: none"> • Your sleep • Your concentration/memory • Mood/anxiety/irritability • Your energy for activities after work 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Are you receiving psychological support?	<input type="checkbox"/>	

Please complete the following questionnaire:

Perceived Stress Scale (PSS 10)

This test is the most commonly used and simplest tool to assess an individual's perception of stress. The result is not a medical diagnosis. It gathers information about the potential need to adjust aspects of your personal or professional life and, if necessary, seek medical or psychotherapeutic help.

The test won't take much of your time. Answer quickly and as spontaneously as possible. The questions relate to your feelings over the past month.

Check the box that best reflects how you have felt over the past month:	Never	Rarely	Sometimes	Fairly Often	Very Often
1. Have you been upset by an unexpected event?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Did you feel it was difficult to control the important things in your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Have you felt nervous and stressed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Did you feel confident in your ability to handle your personal problems?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Did you feel that things were going the way you wanted?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Did you feel that you could not cope with all the things you had to do?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Were you able to control your irritation?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Did you feel that you were on top of things?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Have you felt irritated because events were out of your control?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Did you feel that difficulties piled up to the point that you could not overcome them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>