UCLouvain

Service d'aide aux étudiants

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MEDICAL QUESTIONNAIRE / CONFIDENTIAL

STUDENT

SURNAME . . . . . .

FIRST NAME . . . . . .

GENDER ☐ F ☐ M ☐ OTHER

DATE OF BIRTH . . . . . / . . . . . / . . . . . .

NATIONALITY . . . . . .

ADDRESS STREET . . . . . N° . . . . . BTE . . . . . .

POSTCODE . . . . . TOWN . . . . . .

PHONE NUMBER . . . . . .

E-MAIL . . . . . .

STUDIES

What faculty are you enrolled in?

Health Sciences Sector

☐ Médecine ☐ Pharmacie/SBIM ☐ ESP (École 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:

- ☐ in good health
- ☐ has a serious condition:
  - ☐ hypertension
  - ☐ hypercholesterolemia
  - ☐ diabetes
  - ☐ other . . . . . .
- ☐ dead

YOUR MOTHER IS:

- ☐ in good health
- ☐ has a serious condition:
  - ☐ hypertension
  - ☐ hypercholesterolemia
  - ☐ diabetes
  - ☐ other . . . . . .
- ☐ dead

What other medical history do you have among family members?

. . . . . .

. . . . . .

. . . . . .

. . . . . .

VACCINATIONS

PLEASE REMEMBER TO BRING YOU VACCINATION CARD OR BOOKLET

Give the date of vaccination:

☐ Tetanus – Diphteria (booster): . . . . . .

☐ Polio : . . . . . .

☐ Measles-mumps-rubella (MMR)

1st dose: . . . . . 2nd dose: . . . . . .

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

1st dose: . . . . . 2nd dose: . . . . . .

3nd dose: . . . . . 4nd dose (if relevant): . . . . . .

☐ Tuberculosis (BCG): . . . . . .

LIFESTYLE

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

Do you smoke ?

☐ no

☐ yes, every day ☐ yes, occasionally If yes, ... cigarettes per day

Do you ever use drugs?

☐ never ☐ occasionally ☐ regularly

Do you drink alcohol?

☐ yes ☐ no

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

☐ no, how often: . . . . . .

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

Do you do sport regularly?

☐ yes ☐ no

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

Sport(s): . . . . . .

. . . . . .

How have you adapted to being at University ?

☐ satisfactorily ☐ unsatisfactorily

Do you have family, friends or neighbours you can turn to if you need help or need to confide in someone ? ☐ yes ☐ no

YOUR CURRENT STATE OF HEALTH

DO YOU SUFFER OR HAVE EVER SUFFERED FROM

Respiratory problems (asthma, pneumonia, bronchitis, tuberculosis etc.) ☐ yes ☐ no

If yes, state which . . . . . Were they treated? ☐ yes ☐ no

Ear, nose and throat problems (recurrent sore throats, otitis, sinusitis, deafness, vertigo etc.) ☐ yes ☐ no

If yes, state which . . . . . Were they treated? ☐ yes ☐ no

Cardiac and/or vascular problems (cardiac malformation, arterial hypotension or hypertension, acute rheumatic fever, irregular heartbeats etc.) ☐ yes ☐ no

If yes, state which . . . . . Were they treated? ☐ yes ☐ no

Digestive problems (stomach ache, diarrhoea, vomiting etc.) ☐ yes ☐ no

If yes, state which . . . . . Were they treated? ☐ yes ☐ no

Urino-genital problems (cystitis, kidney stones albuminuria etc.) ☐ yes ☐ no

If yes, state which . . . . . Were they treated? ☐ yes ☐ no

Sexually transmitted diseases ☐ yes ☐ no

If yes, state which . . . . . Were they treated? ☐ yes ☐ no

Vision problems ☐ yes ☐ no

Corrected by glasses or contact lenses ☐ yes ☐ no

Date of last visit to optician . . . . . .

Problems with the osteo-articular system ☐ yes ☐ no

If yes, state which . . . . . .

Skin problems ☐ yes ☐ no

If yes, state which . . . . . Were they treated? ☐ yes ☐ no

Endocrine problems (diabetes, goitre, hypothyroidism or hyperthyroidism) ☐ yes ☐ no

If yes, state which . . . . . Were they treated? ☐ yes ☐ no

Problems relating to blood, lymph nodes, bone marrow (e.g. anaemia,haemorrhage, phlebitis) ☐ yes ☐ no

If yes, state which . . . . . Were they treated? ☐ yes ☐ no

Tropical diseases (e.g. malaria) ☐ yes ☐ no

If yes, state which . . . . . Were they treated? ☐ yes ☐ no

Problems of the nervous system (e.g. epilepsy, meningitis, headaches) ☐ yes ☐ no

If yes, state which . . . . . Were they treated? ☐ yes ☐ no

Problems of anxiety and/or depression ☐ yes ☐ no

Drugs taken . . . . . .

Have you been a victim or witness of sexual assault? ☐ yes ☐ no

. . . . . .

Do you have any questions about your sexuality? ☐ yes ☐ no

. . . . . .

Are you currently taking any drugs? ☐ yes ☐ 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 underline.

Illnesses Tobacco Food
Sleep Pains Alcohol Loneliness
Feeling apart Unhappiness
Relationships
Addictions Appetite
Stress
Family
Sadness

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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.
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