STM
SERVICE DE SANTÉ
AU TRAVAIL MULTISECTORIEL

Medical history questionnaire

Before completing the questionnaire, make sure that:

- your employer has made a request for you to pass a medical examination at STM,
- the company you are working for is affiliated to STM.

If one or more of these requirements are not satisfied, your questionnaire will not be considered and will be destroyed in order to respect the requirements of the RGDPR.

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When to use the following Medical History Questionnaire?

Due to the current health crisis and in order to reduce as much as possible the presence of employees, some recruitment medical examinations will be replaced with an examination based on medical records. The process is as follows:

1. The employer sends to STM the "Demande patronale" for the recruitment medical examination.

*It concerns the recruitment for the following jobs:

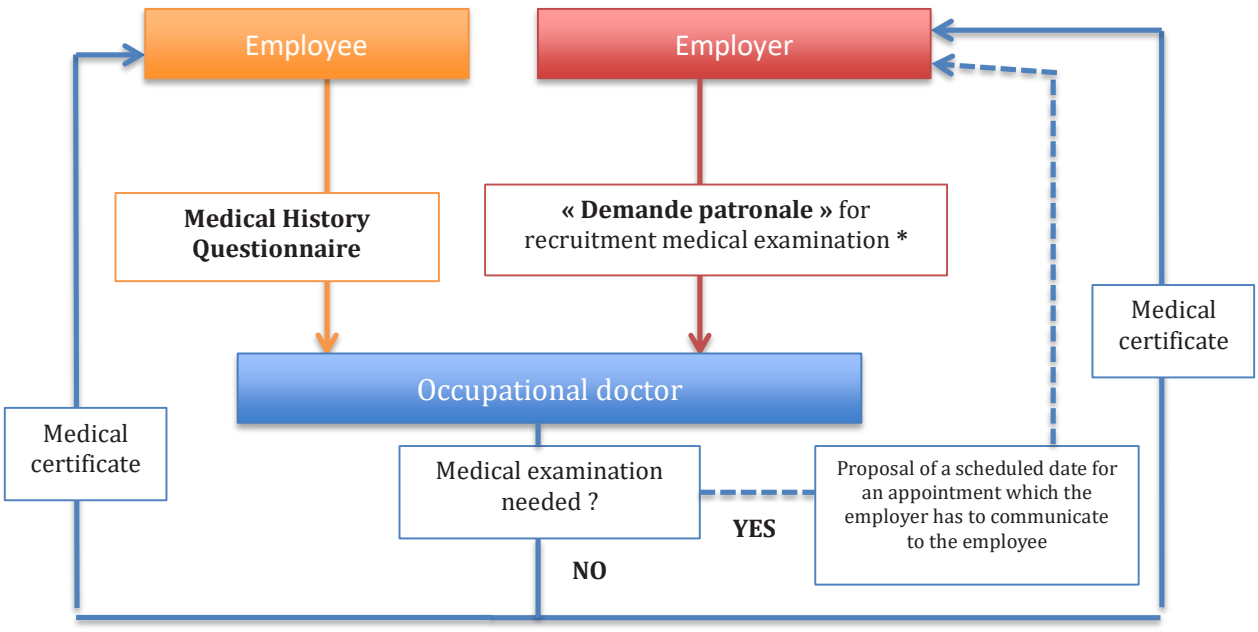
- Office work,
- Administrative employee,
- IT employee,
- Waiter/waitress,
- Salesperson (apart from shelf filler, food sale and sale of automotive equipment

2. The employee completes and submits to STM the attached « Medical History Questionnaire ».

3. On the basis of the questionnaire **and « demande patronale »**, the occupational doctor either confirms on the medical aptitude or requests an appointment for the employee. **Without the « demande patronale » sent by the employer, the demand will not be processed.**

4. In case of medical aptitude, a copy of the medical certificate will be sent to both the employer and the employee.
If a medical consultation is needed, an appointment will be proposed to the employer who will inform the employee of the scheduled date.

If necessary, an appointment can always be requested by the employee or the employer.



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MEDICAL HISTORY QUESTIONNAIRE

THIS FORM MUST BE FILLED IN BY THE EMPLOYEE AND RETURNED TO THE OCCUPATIONAL PHYSICIAN BY MAIL FOR ADVISORY OPINION! PLEASE DO NOT SEND IT BACK TO THE EMPLOYER!
THIS QUESTIONNAIRE WILL ONLY BE HANDLED BY THE OCCUPATIONAL DOCTOR AFTER RECEIVING THE "DEMANDE PATRONALE" SENT BY THE EMPLOYER.

EMPLOYEE INFORMATION

Maiden name: _____ First name: _____

Social security number ☐☐☐☐ ☐☐ ☐☐ ☐☐☐ ☐☐
(in the same order as specified on the employer application):

Street name and house number: _____

Postal code: _____ Location: _____

In-house job description: _____

EMPLOYER INFORMATION

Company name: _____

Please fill in the appropriate answer for each question: *Every question has to be answered

	DID YOU HAVE OR DO YOU HAVE:	YES *	NO *
1	Heart diseases, vascular diseases (high blood pressure, heart attack, fainting spells with or without loss of consciousness)? If yes, which type of:	☐	☐
2	Breathing difficulties, allergies, lung diseases? If yes, which type of:	☐	☐
3	Diseases of the abdominal organs (stomach, liver, intestines ...)? If yes, which type of:	☐	☐
4	Kidney and/or urinary tract diseases (infections, kidney/ureter stones ...)? If yes, which type of:	☐	☐
5	Blood disorders? If yes, which type of:	☐	☐
6	Infectious diseases with increased severity? If yes, which type of:	☐	☐
7	Metabolic disorders : diabetes mellitus, thyroid diseases ? If yes, which type of: ..... - Accompanied by fainting spells? If yes, which type of fainting spells:	☐ ☐	☐ ☐
8	Bone and joint diseases, fractures or late articular effects after an accident, backache? If yes, which type of:	☐	☐

	DID YOU HAVE OR DO YOU HAVE:	YES*	NO*
9	Neurological diseases (vertigo, dizziness, loss of consciousness, epilepsy, sleep apnea syndrome ...)? If yes, which type of:	☐	☐
10	Psychiatric disorders? - Do you suffer from depression? If yes, which type of:	☐	☐
11	Eye diseases? If yes, which type of: ..... Have you had any eye surgery? If yes, which type of:	☐ ☐	☐ ☐
12	Have you undergone rehabilitation programme in the past or currently? If yes, which type of:	☐	☐
13	Regular intake of medication? If yes, which type of:	☐	☐
14	Do you consume the following substances regularly? - Alcohol? If yes, how many glasses a day?..... - Cannabis? - Stimulant drugs/amphetamine/speed? - Other drugs?	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
15	Did you suffer or do you suffer from any other health problems that are not mentioned here? If yes, which type of:	☐	☐
16	Do you smoke? If yes, how many cigarettes a day?..... Are you a former smoker?	☐ ☐	☐ ☐
17	Do you have regular physical activity? If yes, what type of physical activity?..... In what regularity?.....	☐	☐

I, the undersigned, Mr/Mrs/Ms .....
hereby confirm that I have completed this questionnaire regarding my state of health without leaving out any important information.
The information provided is correct and fully true. The answers to this questionnaire are an integral part of my medical record and are therefore treated in the strictest confidence.
I am aware of the legal consequences I can face for intentional misrepresentation.

Please send the original signed by mail to:
Service de Santé au Travail Multisectoriel
32, rue Glesener
L-1630 LUXEMBOURG

Date and signature of the declarant,