STM
SERVICE DE SANTÉ
AU TRAVAIL MULTISECTORIEL

Medical history questionnaire for seasonal workers

This questionnaire is used as part of the medical check-up for staff working in seasonal jobs WITHOUT DRIVING MACHINES. On the basis of the questionnaire, the occupational physician will decide either whether the employee is fit or whether he should be called for a medical examination.

The questionnaire cannot be taken into consideration for any other purpose than seasonal work, and will be destroyed in order to comply with the requirements of the GDPR.

Please send the original signed by mail to:

Service de Santé au Travail Multisectoriel
32, rue Glesener
L-1630 LUXEMBOURG

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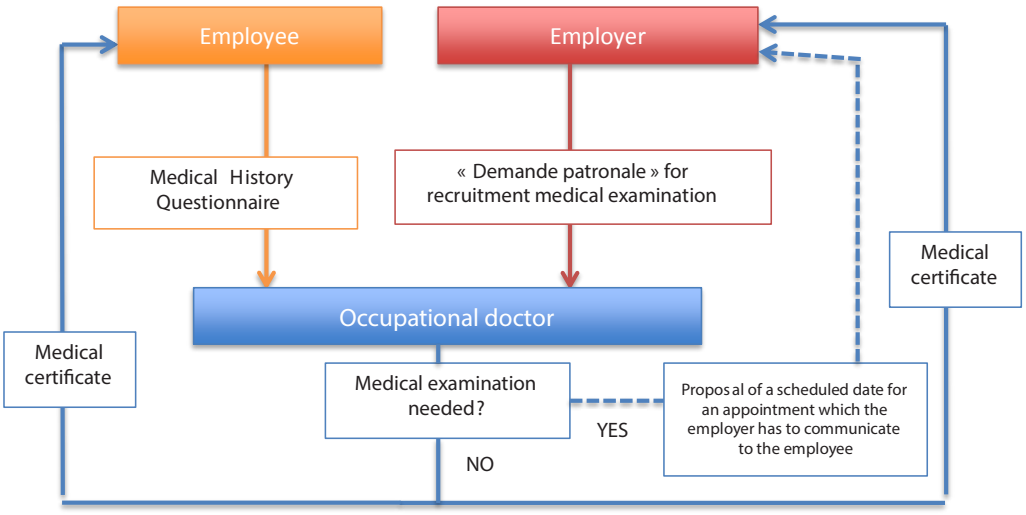
How to proceed ?

1. The employer sends the EMPLOYER APPLICATION form **«Demande patronale»** to the STM for the preemployment medical examination of his employee.
2. The employee sends the completed **«Medical history questionnaire»** below to the STM.
3. On the basis of the **questionnaire and the employer's application form**, the occupational physician will make a decision about the medical aptitude or request 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 necessary, an appointment can always be requested on behalf of the employee or the employer.
If, regarding the items of the questionnaire, a consultation is required , an appointment will be offered to the employer who will be in charge of informing his employee of the scheduled date.



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MEDICAL HISTORY QUESTIONNAIRE FOR SEASONAL WORKERS

THIS FORM MUST BE COMPLETED BY THE EMPLOYEE AND HIS TREATING PHYSICIAN RETURNED TO THE OCCUPATIONAL PHYSICIAN BY MAIL TOGETHER WITH THE DOCUMENTS REQUESTED BELOW FOR ADVISORY OPINION.

PLEASE DO NOT SEND IT BACK TO THE EMPLOYER

EMPLOYEE INFORMATION

Maiden name _____ First name _____

Social security number / or date of birth ☐☐☐☐ ☐☐ ☐☐ ☐☐☐ ☐☐
year *month* *day*

Street name and house number _____

Postal code _____ Location _____

Telephone number: _____

Company name: _____

In-house job description: _____

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, cardiac rhythm disorder...)? If yes, which type of ..... Year of occurance ..... Have you recovered to this day? If so, please describe any sequelae	☐ ☐	☐ ☐
2	Breathing difficulties (asthma...), allergies, lung diseases? If yes, which type of ..... Year of occurance ..... Have you recovered to this day? If so, please describe any sequelae	☐ ☐	☐ ☐
3	Diseases of the abdominal organs (stomach, liver, intestines...)? If yes, which type of ..... Year of occurance ..... Have you recovered to this day? If so, please describe any sequelae	☐ ☐	☐ ☐
4	Kidney and/or urinary tract diseases (infections, kidney/ureter stones...)? If yes, which type of ..... Year of occurance ..... Have you recovered to this day? If so, please describe any sequelae	☐ ☐	☐ ☐

	DID YOU HAVE OR DO YOU HAVE:	YES *	NO *
5	Blood disorders? If yes, which type of ..... Year of occurance ..... Have you recovered to this day? If so, please describe any sequelae	☐ ☐	☐ ☐
6	Infectious diseases with increased severity? If yes, which type of ..... Year of occurance ..... Have you recovered to this day? If so, please describe any sequelae	☐ ☐	☐ ☐
7	Metabolic disorders: diabetes mellitus, thyroid diseases? If yes, which type of ..... Year of occurance ..... Have you recovered to this day? If so, please describe any sequelae ..... - Accompanied by fainting spells? If yes, which type of fainting spells	☐ ☐	☐ ☐
8	Bone and joint diseases, tendinitis, fractures or late articular effects after an accident, backache? If yes, which type of ..... Year of occurance ..... Have you recovered to this day? If so, please describe any sequelae	☐ ☐	☐ ☐
9	Neurological diseases (balance disorder: vertigo, dizziness, loss of consciousness, epilepsy, obstructive sleep apnoea syndrome, brain tumor...)? If yes, which type of ..... Year of occurance ..... Have you recovered to this day? If so, please describe any sequelae	☐ ☐	☐ ☐
10	Suffered from nervous breakdown? If yes, year of occurance ..... Have you recovered to his day?	☐ ☐	☐ ☐
11	Psychiatric disorders? If yes, which type of ..... Year of occurance ..... Have you recovered to this day? If so, please describe any sequelae ..... - Do you suffer from nervous breakdown?	☐ ☐	☐ ☐
12	Eye diseases? If yes, which type of ..... Year of occurance ..... Have you recovered to this day? If so, please describe any sequelae ..... Have you had any eye surgery? If yes, which type of ..... Do you wear glasses or contact lenses? If so, which ones (to see from afar, to see up close, progressive lenses...)?	☐ ☐	☐ ☐

	DID YOU HAVE OR DO YOU HAVE:	YES *	NO *
13	Problems with the nose, throat, ears (tinnitus), tongue? If yes, which type of ..... Year of occurance ..... Have you recovered to this day? If so, please describe any sequelae	☐ ☐	☐ ☐
14	Skin problems (irritation, allergy, eczema...)? If yes, which type of ..... Year of occurance ..... Have you recovered to this day? If so, please describe any sequelae	☐ ☐	☐ ☐
15	Surgeries? If yes, which type of ..... Year of occurance ..... Have you recovered to this day? If so, please describe any sequelae	☐ ☐	☐ ☐
16	Did or do you suffer from any other health problems that are not mentioned here? If yes, which type of ..... Year of occurance ..... Have you recovered to this day? If so, please describe any sequelae	☐ ☐	☐ ☐
17	Do you take medication? Regular intake of medication? If yes, which?	☐	☐
18	Do you have regular physical activity? If yes, what type of physical activity ..... How regular?	☐	☐
19	Do you smoke? If yes, how many cigarettes a day? ..... Are you a former smoker?	☐ ☐	☐ ☐
20	Do you consume the following substances regularly? - Alcohol? If yes, how many glasses a day?.....	☐	☐
21	Do you regularly take drugs? If yes, which drugs do you take (cannabis, stimulants, other drugs)?	☐	☐
22	Have you undergone detoxification in the past or currently? If yes, which type of	☐	☐

Your weight (kg) : _____ **Your height (m) :** _____

Please attach to this document:
- **a copy of your vaccination card,**
- any **copy(s) of your medical report(s)** which you deem useful for decision making.

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.

Date and handwritten signature of the declarant *(mandatory)*	**Date and handwritten signature of the treating physician** *(mandatory)*

Please send the original signed by mail to: STM - 32, rue Glesener - L-1630 LUXEMBOURG