STM
SERVICE DE SANTÉ
AU TRAVAIL MULTISECTORIEL

MEDICAL HISTORY QUESTIONNAIRE FOR THE PURPOSE OF THE EUROPEAN UNION QUALIFICATION LICENSE FOR INLAND SHIPPING

PERSONAL 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 _____

Position held:
☐ Boatmaster ☐ Boatman ☐ Deck Crew Member ☐ Passenger Navigation Expert
☐ Helmsman ☐ Able Boatman ☐ Liquefied Natural Gas Expert (LNG)

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	☐ ☐	☐ ☐
5	Blood disorders? If yes, which type of ..... Year of occurance ..... Have you recovered to this day? If so, please describe any sequelae	☐ ☐	☐ ☐

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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?	☐ ☐ ☐	☐ ☐ ☐
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	☐ ☐	☐ ☐
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	☐	☐

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.

This questionnaire, duly completed and signed, is to be presented to the occupational physician during the medical examination

Date and handwritten signature of the declarant
(mandatory)