HEALTH CENTER
CLINIQUE LÉMANA

Medical questionnaire

Personal data

Name

First name

Sexe
Male Female

E-mail

Are you pregnant?
Yes No

Weight

Height

Date of birth

Compte facebook

Please check the appropriate boxes

Liver and pancreatic diseases
Hepatitis
Other

Diabetes
Yes No
Insuline
Medication ?

Cancer
Yes No
Which organs ?
Surgery Radiotherapy Chemotherapy
If yes
from
until

Allergies
Yes No
If yes, what ?

Articular rheumatism
Yes No

Respiratory disorders
Asthma Emphysema
If yes, what ?

Have you already had a cell therapy ?
Yes No
If yes, when ?
If yes, where ?

Thyroid disease ?
Yes
If yes, what ?

Cardiac disorders
Heart attack
Date
Stent Chest angina Arterial hypertension

Infections
HIV Tuberculosis
If yes, when ?
Other

Your habits
Do you smoke ?
Yes No
Do you drink alcohol ?
Yes No
How much per day dl

Other illnesses

Do you take medications ?
Yes No
If yes, name of the medication