HEALTH CENTER
CLINIQUE LÉMANA

Medical questionnaire

Personal data

Name

First name

E-mail

Facebook profil

Date of birth

Sexe

Male Female

Height

Weight

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