HÔPITAL FONDATION
Adolphe de ROTHSCHILD
LA RÉFÉRENCE TÊTE ET COU

SPECIALIZED MEDICAL CHECKUP IN PARIS

Medical questionnaire

To be completed and returned to us by email so that we can propose you the most suitable specialized medical check up

Email : international@for.paris

Tél : +33 1 48 03 63 00

PERSONAL INFORMATION

Last Name : First Name :

Date of Birth: Place of Birth:

Address :

Postal Code: City: City :

Country :

Email address:

Mobile number:

LIFESTYLE

Do you smoke? ☐ Yes ☐ No

If yes, what? .... Quantity per day: ....

If you quit, year of cessation: ....

Do you use drugs? ☐ Yes ☐ No

Do you engage in physical activity? ☐ Yes ☐ No

If yes, which one? ....

How often? ....

Do you consume alcoholic beverages ☐ Yes ☐ No

What type?...

How often? ....

FAMILY HISTORY:

In your family, are you aware of the following conditions?

	Father	Mother	Siblings
coronary heart disease (chest pain, heart attack)	☐	☐	☐
Stroke	☐	☐	☐
Diabetes	☐	☐	☐

Type : With or without insulin?	☐	☐	☐
Arterial hypertension	☐	☐	☐
Dyslipidemia, hypercholesterolemia	☐	☐	☐
Parkinson's disease	☐	☐	☐
Alzheimer's disease	☐	☐	☐
Serious hereditary diseases Which one or ones?...	☐	☐	☐

Death of a parent? ☐ Yes ☐ No

Age : ....

Cause :

....

MORPHOLOGY :

Height(m) .... Weight (kg) ....
Recent weight variation? ....
If yes, how many
kilograms?.....................................
For what reasons?...

PERSONAL HISTORY:

Have you been treated or are currently being treated for any of the following conditions? (Check the corresponding boxes)

High blood pressure	☐	Meniere's disease	☐
Heart attack/angina	☐	Otospongiosis	☐
Heart failure	☐	Hearing loss	☐
Atrial fibrillation/rhythm disorders	☐	Sinusitis	☐
Endocarditis	☐	Upper airway cancer	☐
Asthma/Chronic bronchitis	☐	Hypo or hyperthyroidism	☐
Respiratory failure	☐	Pituitary adenoma	☐
Tuberculosis	☐	Glaucoma	☐
Epilepsy/seizures	☐	Cataracts	☐

Loss of consciousness	☐	Uveitis	☐
Stroke	☐	Horton's disease	☐
Subarachnoid hemorrhage	☐	Disc herniation	☐
Parkinson's disease	☐	Spinal stenosis	☐
Alzheimer's disease/Dementia	☐	Facial pain	☐
Myasthenia gravis	☐	Migraines	☐
Multiple sclerosis	☐	Renal failure	☐
Brain tumor	☐	Diabetes	☐
Depression	☐	Liver failure, cirrhosis	☐
Psychiatric disorders	☐	Rheumatoid arthritis, Ankylosing spondylitis	☐

Have you ever undergone surgery? Oui ☐ non ☐

If yes, which one(s)?	Date	Possible complications
....	....	....
....	....	....
....	....	....
....	....	....

Have you stayed in a hospital, clinic ?:

☐ Yes ☐ No

If yes, for what reasons?...

Medical follow-up: ....

Are you following a treatment?

☐ Yes ☐ No

If yes, which one?

Medication	Dosing frequency

CURRENT SYMPTOMS:

Have you experienced any of the following symptoms in the past few months ?

	Yes	No
Headaches	☐	☐
Double Vision	☐	☐
Decreased visual acuity, blurred vision	☐	☐
Drooping Eyelid	☐	☐
Speech dificulties,difficulty finding words	☐	☐
Paralysis of a limb or part of the face	☐	☐
Redness or eye pain	☐	☐
Decreased hearing	☐	☐
Dizziness or feeling of instability	☐	☐
Nausea,Vomiting	☐	☐
Seizures	☐	☐
Abnormal movements	☐	☐
Discomfort, loss of consciousness	☐	☐
Chest pain	☐	☐
Swallowing dificulties, choking	☐	☐
Food blockages	☐	☐
Voicess changes	☐	☐
Dental pain	☐	☐
Back pain (neck, lower back)	☐	☐
Pain in a limb or part of the face	☐	☐
Shortness of breath with effort	☐	☐
Memory problmens	☐	☐

Walking difficulties		

Other symptoms not mentioned above but needing to be reported :

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Comments or questions you wish to discuss with the examining physician?

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