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completed on: ____/____/____

Patient:
Mr / Mrs / X: First name: Last name: Date of birth: / /
Phone number:

Dear Patient,
In preparation for the examination, we ask you to complete this questionnaire and hand it in at the registration desk.

Current complaints:

Current medications:

Medication [mg]	Morning	Noon	Evening	At night	If needed

Intolerance / allergy to medication? ○ YES, against ____________________

Preventive medical checkups:

letzte:	when?
○ Skin cancer screening	________
○ Cancer screening woman	________
○ Cancer screening man	________
○ Health checkup	________

Vaccinations:

Vaccination book available?	○ YES
○ Tetanus	________
○ Diphterie	________
○ Polio (4x?)	________
○ other	________

Chronic diseases:

○ Diabetes
○ High blood pressure
○ High blood fat levels
○ Myocardial infarction
○ Circulatory disease of the coronary arteries
○ Circulatory disorder of the legs
○ Stroke
○ Thyroid disease
○ Allergy - which?
____

○ Respiratory diseases
○ Skin diseases
○ Gastrointestinal diseases
○ Back problems
○ Joint problems
○ Diseases of the kid-neys/urinary tract
○ Cancer
○ Neurological diseases
○ Eyes/ears diseases
○ other
____

Operations/Injuries (when, what?):

Work:

I work as ____________________

Stresses at work:

Size: ________ cm Weight: ________ kg

Smoker? ○ YES, ________/day ○ NO ○ FORMER

Family history (Parents, brothers and sisters?):

○ Diabetes
○ High blood pressure
○ High blood fat levels
○ Myocardial infarction
○ Circulatory disease of the coronary arteries
○ Stroke

○ Respiratory diseases /urinary tract
○ Cancer
○ Neurological diseases
○ Circulatory disorder of the legs

Psychological stresses?

I always wanted to ask my doctor:

- Thank you -