

Dear Patient,

Welcome to our practice!

In order to provide comprehensive advice and high-quality treatment to you, we kindly ask you to answer the following questions.

Your responses are subject to medical confidentiality and will be treated accordingly. The data processing takes place on basis of the legal regulations of the DSGVO.

ANAMNESIS QUESTIONNAIRE FOR PATIENTS

Surname, first name(s): _____

Date of Birth : _____ male: ☐ female: ☐ divers: ☐

Address : _____

Phone number : _____

Fax: : _____

E-Mail : _____

Current job : _____

Emergency number : _____

Occupational status / qualifications : _____ civil status: _____

Children:

Height: -----cm

Weight: -----kg

Childhood diseases:

Measles yes ☐ no ☐

Rubella yes ☐ no ☐

Chicken pox yes ☐ no ☐

Mumps yes ☐ no ☐

Scarlet fever yes ☐ no ☐

Polio yes ☐ no ☐

**Pre-existing conditions:**

High blood pressure	yes ☐	no ☐	Tuberculosis	yes ☐	no ☐
Heart Attack	yes ☐	no ☐	Joint diseases	yes ☐	no ☐
Diabetes mellitus	yes ☐	no ☐	Skin disease	yes ☐	no ☐
Gastrointestinal diseases	yes ☐	no ☐	Eye diseases	yes ☐	no ☐
Liver diseases	yes ☐	no ☐	Apoplex/Stroke	yes ☐	no ☐
Kidney diseases	yes ☐	no ☐	Asthma	yes ☐	no ☐
Lipid metabolic disorder	yes ☐	no ☐	Seizure disorders	yes ☐	no ☐
Urea change disease	yes ☐	no ☐	Tumor disease	yes ☐	no ☐
Mental illness	yes ☐	no ☐	Aids	yes ☐	no ☐

Operations?

Accidents?

Do you have vaccination protection:

Tetanus	yes ☐	no ☐	Mumps	yes ☐	no ☐
Diphtherie	yes ☐	no ☐	Rubella	yes ☐	no ☐
Polio	yes ☐	no ☐	Hepatitis A	yes ☐	no ☐
BCG-Tuberkolosis	yes ☐	no ☐	Hepatitis B	yes ☐	no ☐

Allergys:

Antibiotics	yes ☐	no ☐	which? _____
Other medicines	yes ☐	no ☐	which? _____
Pollen/House dust	yes ☐	no ☐	
Animal hair	yes ☐	no ☐	
Food	yes ☐	no ☐	

Family History (first degree relatives)?

Diabetes mellitus	yes ☐	no ☐	Lung diseases	yes ☐	no ☐
Heart Attack	yes ☐	no ☐	Tumor diseases	yes ☐	no ☐
Lipid metabolic dis.	yes ☐	no ☐	Apoplex	yes ☐	no ☐
Kidney diseases	yes ☐	no ☐	mental illnesses	yes ☐	no ☐

If yes, please specify including the relative affected

Others: _____

General:

Smoking	yes ☐	no ☐	How much?
Alcohol	yes ☐	no ☐	How much?
Drugs	yes ☐	no ☐	What?

Regular use of medication? yes ☐ no ☐

Which/amount? :



When was your last Check-Up? _____

When was your last Prostate cancer screening? _____

When was your last Skin cancer screening? _____

Gyn.History:

First period? _____

Last period? _____

Pill for contrazeption? _____

Regular gynecological checks? _____

Pregnancies? _____

Period on reguklar basis? _____

Intracyclic menstual bleeding? _____

Gynaekologist: _____

How did you became aware of our pracitice?

Personal recommendation: yes ☐

Phone book yes ☐

Internet yes ☐

Others

Thanks a lot, that you have taken the time to answer the questions.

Date: _____

Signature Patient: _____