Medical history questionnaire

name: _____ first name: _____

date of birth: _____ profession: _____

height&weight: _____ phone: _____

mailadress: _____

We will only use your adress for a newsletter (max. 4/annum). Your address won't be given to anyone else.

previous illnesses:

hypertension:	yes □	no □
diabetes mellitus:	yes □	no □
hyperlipidemia:	yes □	no □
heart disease:	yes □	no □
asthma/lung diseases:	yes □	no □
cancer:	yes □	no □

other illnesses:

_____

surgeries:

_____

others:

allergies / intolerances against medications? Which? :

_____

_____

smoker: yes □ no □ how many per day: _____

vaccinations:

vaccination document exists (please bring it with you): yes □ no □

chief complaints:

_____

_____

_____

I take these medications regularly:

_____

_____

Illnesses in the family:

hypertension:	yes □	no □
diabetes mellitus:	yes □	no □
hyperlipidemia:	yes □	no □
heart disease:	yes □	no □
asthma/lung diseases:	yes □	no □
cancer:	yes □	no □

Do you have an advance decision / living will?

yes □ no □

further questions to the doctor:

_____

_____

How did you become aware of us? **internet □** **personal recommendation □** **flyer □** **parish newsletter □** **Yellow pages □**