Examination Questionnaire

Date:

Dear Sir or Madam,

The following questions deal with you and your medical history. They help to clarify your state of health and simplify our following conversation. It is therefore in your own interest to answer the questions (front and back) **thoroughly** and **carefully**.

Please write and cross the boxes clearly.

Your answers are bound to professional discretion.

Surname, first name	
Date of birth	
Place of birth	
Postal code and residence	
Street and house no.	
Telephone	
Current job position	
Employer	
Family doctor (Name and address)	

Have you ever had any of the following illnesses ?

	no	yes	Doctor´s notes
• Epilepsy, impared consciousness	☐	☐	_____
• Dizziness, other imbalances	☐	☐	_____
• Stroke, paralysis	☐	☐	_____
• Carcinosis	☐	☐	_____
• Nervous complaints, psychological illness	☐	☐	_____
• Eye diseases	☐	☐	_____
• Ear diseases	☐	☐	_____
• Heart attack	☐	☐	_____
• Other heart or vascular diseases	☐	☐	_____
• Aneamia, hemic diseases	☐	☐	_____
• Varicose veins, thrombosis, venous leg ulcers	☐	☐	_____
• High blood pressure	☐	☐	_____
• Lung diseases / chron. bronchitis	☐	☐	_____
• Asthma, hay fever, allergies	☐	☐	_____
• Diabetes	☐	☐	_____
• Thyroid dysfunctions	☐	☐	_____

Please turn page !

	no	yes	Doctor´s notes
• Gastrointestal illnesses, ulcers	☐	☐	_____
• Jaundice, liver diseases, gallstones	☐	☐	_____
• Nephritis or bladder infections/stones	☐	☐	_____
• Spine, joint or muscular ailments	☐	☐	_____
• Rheumatism,rheumatic fever, gout	☐	☐	_____
• Broken bones	☐	☐	_____
• Accidents	☐	☐	_____
• Skin diseases	☐	☐	_____
• Breathing dysfunktions related to sleeping	☐	☐	_____
• Other illnesses. If yes, please specify which ones ? (infectious diseases, thyroidal dysfunktions, genital organ illnesses)	☐	☐	_____

_____

_____

- Have you had any operations ? If yes, when and which ones ? no ☐ yes ☐

_____

_____

Further questions regarding yourself:

Do you drink alkohol? Regularly ☐ Occasionally ☐ never ☐

	no	yes
Do you do sport?	☐	☐
Do you smoke (cigarettes, cigars, pipes)?	☐	☐
Have you ever smoked?	☐	☐
Do you/have you take(n) medicine regularly?	☐	☐

If yes, what do you/have you take(n)? (incl. pain killers and sleeping tablets)

_____

_____

Declared severe disability. If yes, to which degree (percentage)?	☐	☐
Change of work place for health reasons ?	☐	☐
Driving license restrictions?	☐	☐

_____

_____

Signature patient:.....

Passport checked by CAB ☐