Health Questionnaire

Date:

The following questions concern your data and medical history. They help us to clarify your health status and facilitate our examination. Therefore, it is fundamental to answer these questions (front and back) **thoroughly** and **carefully**.

Please write and cross the boxes clearly.

Your answers are bound to medical confidentiality.

Surname, first name	
Date of birth	
Place of birth	
Postal code and city	
Street and house number	
Telephone / mobile	
Current job position	
Employer	
Department/branch/division	
Family physician / GP	

Have you ever had any of the following illnesses?

	Yes	No	Doctor´s notes
• Epilepsy, seizures, neurological diseases	☐	☐	_____
• Dizziness, balance disorders	☐	☐	_____
• Stroke, paralysis	☐	☐	_____
• Cancer	☐	☐	_____
• Mental or psychological illnesses	☐	☐	_____
• Eye diseases	☐	☐	_____
• Ear diseases	☐	☐	_____
• Heart attack	☐	☐	_____
• Other heart or vascular diseases	☐	☐	_____
• Aneamia, blood diseases	☐	☐	_____
• Varicose veins, thrombosis, venous leg ulcers	☐	☐	_____
• High blood pressure	☐	☐	_____
• Lung diseases / chronic bronchitis / asthma	☐	☐	_____
• Allergies, hay fever	☐	☐	_____
• Diabetes	☐	☐	_____
• Thyroid diseases	☐	☐	_____

Please turn the page!

	Yes	No	Doctor´s notes
• Sleep disorders/apnoea, snoring, daytime sleepiness	☐	☐	_____
• Gastrointestal illnesses, duodenal ulcer	☐	☐	_____
• Jaundice, liver diseases, gallstones	☐	☐	_____
• Kidney or bladder diseases/stones	☐	☐	_____
• Spine, joint or muscular ailments	☐	☐	_____
• Rheumatism, rheumatic fever, gout	☐	☐	_____
• Broken bones	☐	☐	_____
• Accidents	☐	☐	_____
• Skin diseases	☐	☐	_____
• Other illnesses. If yes, please specify which ones? (chronic infectious diseases, genital organ illnesses, autoimmune diseases)	☐	☐	_____

_____

_____

- Have you had any surgeries? **Yes** ☐ **No** ☐

If yes, which ones and when?

_____

_____

Further questions regarding yourself:

	Yes	No	Doctor´s notes
Do you do sports?	☐	☐	_____
Do you drink alcohol?	☐	☐	_____
Do you smoke (cigarettes, cigars, pipe, hookah?)	☐	☐	_____
Have you ever smoked? For how long?	☐	☐	_____
Do you take any drugs?	☐	☐	_____
Do you/have you taken medicine regularly?	☐	☐	_____

If yes, which ones? (incl. pain killers, sleeping or birth control pills)

_____

_____

	Yes	No	Doctor´s notes
Declared severe disability. If yes, which degree?	☐	☐	_____
Change of work place for health reasons?	☐	☐	_____

General Data Protection Regulation - Consent to data processing: *I am aware from the information provided to me by the CAB that this is special personal data (health data, biographical information, etc.) and I consent to the collection, use, processing, storage and transmission of my personal data within the framework of the legal regulations in the European Union (DSGVO).* This agreement can be revoked at any time.

I hereby also confirm the truthfulness and correctness of my information:

Signature: _____