Patient questionnaire

Dear patient,
the following questions concern your person and your medical history. Your information will facilitate the subsequent conversation with your doctor. Thus, the conscientious and complete answering of the questions is in your own interest

This questionnaire will be treated confidentially and will remain in your medical file.

Gender? W M

Marital status: ______________________________

Profession: _________________________________

Phone : ____

Mobile: ____

E-Mail: ____

Why are you visiting the doctor today? ____

Please cross the corresponding answers!

Did you suffer from one of the following diseases?	YES	No	?	Comment on details
1. Typhoid fever / tuberculosis				
2. Glaucoma				
3. Inflammation of the paranasal sinuses				
4. Inflammation oft he thyroid gland				
5. Pneumonia or bronchitis				
6. Asthma, allergies, hay fever				
7. Hypertension / elevated blood pressure				
8 .Stroke, paralysis				
9. Heart attack / cardiac infarction				
10. Other heart diseases or vascular diseases				
11. Varicosis of the veins, thrombosis				
12. Gastric ulcer				
13. Hepatitis / other liver disease / gall stones				
14. Inflammation of kidneys or urinary bladder				
15. Stones in kidneys, bladder or urinary tract				
16. Disease of the prostate gland				
17. Disease of the female genitals				
18. Sexually transmitted diseases (syphilis, gonorrhea, HIV / AIDS and others)				
19. Skin diseases				
20. Nervous breakdown, psychiatric disease				
21. Epilepsy, seizures				
22. Diabetes, elevated blood sugar				
23. Gout, soft tissue rheumatism				
24. Joint related rheumatism				
25. Other diseases of joints or spine				
26. Bone fractures, traumatic accidents				
27. Anemia, diseases of the blood				
28. Malignoma, cancer				
29. Other diseases? (If yes, which kind of disease?)				
30. Have you undergone surgery? (which kind?)				
31. Did you visit tropical countries or the mediterranean area? (within the last year)				

	YES	No	?	Comment on details
32. Do you feel lonely most oft he time?				
33. Are there difficulties in your partnership / marriage?				
34. Are there difficulties in your familiy?				
35. Are you unhappy with your job?				
36. Are you unhappy with your living conditions?				
37. Are you unhappy within your neighbourhood?				
38. Do you encounter other distress?				
39. Have you had lack of success in life?				
40. Do you worry about the future?				
41. Do you drink alcohol on a regular basis? How often and how much do you drink?				
44. Do you smoke?				
45. Did you smoke in the past?				
46. Use of illegal drugs (present or past)?				
47. Do you exercise less than 2 times per week?				
Do you feel that your health is affected by……				
48. Noise/dust/smoke/pollution?				
49. Shiftwork?				
50. Do you take medicine on a regular basis? Which drugs?				
51. Do you take the pill for birth control?				
52. Are you pregnant?				
53. How many children do you have?				
54. How many times were you pregnant?				
Have your relatives suffered from the following diseases?				
55. Hypertension / high blood pressure				
56. Heart attack				
57. Obesity / overweight				
58. Diabetes / high blood sugar				
59. Gout / rheumatism				
60. Nervous or psychiatric diseases				
61. Epilepsy (seizures)				
62. Tuberculosis				
63. Stones in kidneys, bladder or urinary tract				
64. Malignancy / cancer				
65. Addiction / substance abuse				
66. Allergy, asthma				
67 Neurodermitis, chronic eczema				
68. Headaches, migraine				
69. Are you severely disabled? Degree of occupational disability _____%				
70. Have you undergone rehabilitation treatment? (time, place and reason for rehalbilitation)				

Date: ______________________________