**Date: ____ . _____ 202_**

# Dear patients,

**Please review and fill in this important questionnaire. Be sure to note all relevant information including any chronic disease, operations and daily medications. Please fill it out completely.**

**Your treatment will be improved with an accurate and full health history. Thank you for your cooperation.**

## Basic information:

**Family name**: .......................................... **First name**: ................................ **Date of birth**: ..DD.. . ..MM.. . ..YYYY..

**Current Street/Nr.: ................................................... Current City : .......................... Country of origin: ...**..........................

**Mobil : .................. / .......................... Land line : .............. / ............ E-Mail : .....................................**

**sex**: O male O female O diverse **height:** ..... cm **weight**: ........ kg **German speaking contact**: **...................................**

## **Medication** (please include exact dosage) o yes o no

| | Active agent | Branded medication name | morning | noon | evening | night | Other, like „if needed" |
|---|---|---|---|---|---|---|---|
| e.g. | Malus | Tietjenapfel® | 50 mg | — | 25 mg | — | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

## **Operations** o yes o no

| | Operation | when? |
|---|---|---|
| e.g. | appendectomy | august 1997 |
| | | |
| | | |
| | | |

## Vaccination status: **if you have a vaccination certificate, please be sure to provide it.**

If not, please write down the vaccinations you remember, e.g. have you been regularly vaccinated during childhood? When was your last vaccination? Are you vaccinated against COVID-19? Please provide details.

.........................................................................................................................................................................

.........................................................................................................................................................................

.........................................................................................................................................................................

.........................................................................................................................................................................

**Please fill out all pages** **VIELEN DANK! ☺**

## (Chronic) diseases o yes o no

| | Disease | (since) when? | other |
|---|---|---|---|
| e.g. | hypertension | summer 2002 | |
| | | | |
| | | | |
| | | | |

## Regular treatments o yes o no

| e.g. physiotherapy, psychotherapy, regular check-ups |
|---|
| |

## Allergies / Intolerances o yes o no

| | Allergen | What is the reaction? |
|---|---|---|
| e.g. | penicillin | Dermal reaction |
| | | |

## Health risks o yes o no

| | | |
|---|---|---|
| e.g. | smoking, alcohol | e.g. 1 pack of cigarettes daily since 20 years |
| | | |

## Flight-related risks (you don't have to answer those questions, but they are helpful for the doctor)

Please list the countries you travelled through and duration: ……………………………………………………………

……………………………………………………………………………………………………………………………………………

Have you spent time in crowded conditions such as shelters, military bunkers or refugee camps?

If yes, please list locations and duration: ………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………

Have you witnessed or experienced any violence which would like the doctor to know about? ……….

……………………………………………………………………………………………………………………………………………

Have you been in contact with someone who has tuberculosis, e.g. in your family? o yes o no

## Family history

| Please list known diseases in your family, risks from your job or the work of a family member |
|---|
| |
| |

**Please fill out all pages** **VIELEN DANK! ☺**