

Health status questionnaire

(thank you for completing our questionnaire, all the information subordinate to medical secret)

First name:

Telephone:

Surname:

E-mail:

Date of birth:

Insurance company:

Address:

Family history: all relevant diseases by your parents, brothers and sisters and children (chronic diseases like diabetes, high blood pressure, stroke, tumor, mental illness or other)

Your own history:

(common childhood diseases, infectious jaundice, infectious mononucleosis, recurrent tonsillitis, rheumatic fever, heart disease, metabolic disease – diabetes, thyroid gland d., lung d. – f.e. asthma, stomach disease, renal disease, bone and joint disease (gout), blood d., eye d., neurological (epilepsy) or mental disorders, other)

Have you ever been operated? (when, what operation)

Have you ever been in hospital? (when, for what reason?)

Have you sustained an injury? (brain concussion, fractures)

Are you followed about some disease by some specialist?

Have you ever had a blood transfusion?

Do you have any allergy (or intolerance to some foodstuff, drugs or pollen, dust..)?

Are you taking any medication? (including hormonal contraception)

Do you smoke? (If yes, how many cigarettes, per day?)

Do you drink coffee?

Do you drink alcohol drinks (how often, what kind of. alc.)

Are you on a diet?

Sport activities? (in present age, formerly)

Your employment?

Women only: Date of last gynecologic examination?

Mammography?

Date of last tetanus immunisation?

Do you take glasses?

Your weight: high:

Date:

Signature: