PATIENT MEDICAL HISTORY - Dr. med. Katrin Schäfer, General Practitioner

First Name:	Last Name:	
Date of birth: Martial status:	Gender: ◯ male ◯ female ◯ diverse	
Street address:	ZIP code:	City:
Telephone:	E-mail address:	
Profession:	Current job / position:	

Who can we contact in case of emergency? (e.g., Parent, Partner, Child, Friend)
Name: Telephone:

Which of the following childhood diseases have you had? *Check all that apply*

- ☐ Measels
- ☐ Rubella
- ☐ Chicken pox
- ☐ Mumps
- ☐ Scarlett fever

Other:

Which of the following operations have you had? *Check all that apply*

- ☐ Tonsils
- ☐ Appendix
- ☐ Gallbladder
- ☐ Stomach (BI / BII)
- ☐ Uterus
- ☐ Breast
- ☐ Hernia
- ☐ Thyroid

Other:

Which of the following pre-existing conditions do you have or have had? ***Check all that apply***

- ☐ Blood pressure
- ☐ Stomach disease
- ☐ Kidney disease
- ☐ Fat metabolism disorder
- ☐ Joint- / Back pain
- ☐ AIDS
- ☐ Lung disease
- ☐ Psychiatric disease
- ☐ Diabetes
- ☐ Cancer
- ☐ Skin disorder
- ☐ Uric acid metabolic disorder, Gout
- ☐ Tuberculosis
- ☐ Liver disease
- ☐ Heart disease
- ☐ Epilepsy

Other:

Do you have any allergies / intolerances? *Check all that apply*

- ☐ Medicines
- ☐ Aspirin (Acetylsalicylic acid)

If yes, which?

- ☐ Pollen
- ☐ Dust mite
- ☐ Food
- ☐ Animal hair
- ☐ Metal

Describe your allergic reaction:
Other substances:

All data collected is handled with strict confidentialty and is not provided to third parties.

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Do you have family members (blood relatives) who have / have had any of the following diseases? *Check all that apply*

- ☐ Blood pressure
- ☐ Fat metabolism disease
- ☐ Lung disease
- ☐ Stroke
- ☐ Diabetes
- ☐ Heart attack
- ☐ Cancer

If yes, which kind?

Other:

History of the autonomic nervous system *Describe your observations.*

Thirst	○ normal	○ increased
Appetite	○ normal	○ incerased
Bowel movement	○ normal	○ incerased
If not normal,	☐ diarrhea	☐ constipation
If diarrhea,	☐ with blood	☐ with mucus
How often per day?		When?
Urination	○ normal	○ increased
If not normal,	☐ „burning“	☐ difficulties
	☐ more than 1-2 times a night	
Weight	○ constant	○ loss
	○ gain	○ intentional ○ unintentional

Height (in cm): Weight (in kg):

Are you having or have you had mental health issues? ○ ja ○ nein

Which of the following statements applies. *Check all that apply*

- ☐ I am frequently cold.
- ☐ I sweat profusely.
- ☐ I am frequently warm.
- ☐ I have frequent headaches.

I have the following complaints:

- ☐ I smoke. — If yes, how many cigarettes / day and since what age?
- ☐ I drink alcohol ○ yes ○ no — If yes, ○ daily ○ ab und zu
- ☐ I take drugs ○ yes ○ no — What? How much? If yes, ○ daily ○ occasionally
- ☐ I am a recovering alcoholic. — What, how much?
- ☐ I had a drug addiction.

Do you take any medications?	○ yes ○ no
If yes, which?	

Which vaccinations have you had?

☐ Tetanus	☐ Rubella/Mumps
☐ Diphtheria	☐ Whooping cough
☐ Polio	☐ Hepatitis A
☐ Measles	☐ Hepatitis B