Dear patient,

Welcome in the „Praxis am Ponttor". All diseases can have a consequence to your treatment. Please fill this questionnaire very carefully. This questionnaire helps us to treat you in the best way. All your statements are subject to medical confidentiality, the only purpose is to adjust the treatment to your state of health.

Last name: First name: Date of birth:
E-mail Adress: Height:
Phone number/ Mobile Number: Weight:
Your contact number in case of emergency:

(Please fill in the blanks or mark the answer with a cross!)

1. Are you taking **medication** on a regular basis? Nehmen Sie regelmäßig Medikamente ein?
No Yes, if so, wich ones?

2. Do you have any **allergies**, allergic reaction? Neigen Sie zu allergischen Reaktionen?
No Yes, if so, wich ones?

2. Do you smoke? Rauchen Sie?
No Yes

3. Do or did you have one of the following **diseases**? Leiden oder litten Sie an nachfolgenden Krankheiten?

- Contagious diseases? (i.e. Tuberculosis, Hepatitis, Aids)? Infektionskrankheiten No Yes
- Heart disease? (i.e. heart defect, valve defect, inflammation) Herzerkrankungen No Yes
- Liver disease? Lebererkrankungen? No Yes
- High blood pressure? Zu hoher Blutdruck? No Yes
- Stroke? Schlaganfall? No Yes
- Kidney diseases? Nierenerkrankungen? No Yes
- Diabetes? Diabetes? No Yes
- Thyroid diseases? Schilddrüsenerkrankung? No Yes
- Blood diseases ? Blutkrankheiten oder Blutgerinnungsstörungen? No Yes
- Nerve diseases? Nervenerkrankungen? No Yes

4. Did you have any surgery in the last year? Sind Sie im letzten Jahr operiert worden? No Yes

5. Do you have a vaccination card/document? No Yes

6. **For women:** Are you pregnant? Besteht eine Schwangerschaft? No Yes

_____ _____ _____
date Patient signature