PARACELSUS CLINIC

Medical History Questionnaire

Please fill in the following questionnaire completely. Your medical history is very important for a proper treatment and therapy plan. Please take your time and answer as accurately as possible. If there is not enough space, please use a separate page.

Bitte in Blockschrift ausfüllen

Title ☐ Ms. ☐ Mrs. ☐ Mr.

Last name:

First name:

Date of birth *(DD.MM.YYYY)***:**

Street, House number:

Country /City/ZIP code:

Phone:

Mobile: (mit area code)

E-Mail:

Length of stay / intended duration

☐ Married ☐ Single Occupation:

Children: (how many, gender, age)

Do you have a dental panorama x-ray (OPT) *not older than 1 year* ☐ Yes ☐ No

Emergency contact person:

(name, address, phone, e-mail)

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1. What is your main health problem/diagnosis including main symptoms?

2. Do you have any additional diseases / illnesses or symptoms?

3. Please list any previous illnesses, operations or accidents chronologically:

4. What medications/drugs are you taking currently? (biological and pharmaceutical drugs)

5. What is your height in cm? What is your current weight in kg? What is your blood group?

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6. Please, select appropriate answer und make comments where necessary.

#		normal	too little	too much	Comment
1	Appetite / thirst	☐	☐	☐	
2	Digestion / bowel movement	☐	☐	☐	
3	Exercise	☐	☐	☐	

#		no	yes	Comment
4	Sleep disturbances	☐	☐	
5	Dental problems	☐	☐	
6	Do you have amalgam fillings?	☐	☐	
7	Do you have root-treated teeth?	☐	☐	
8	Cardio vascular problems / heart disease	☐	☐	
9	High blood pressure / low blood pressure	☐	☐ *	
10	Pulmonary problems, short of breath, Asthma	☐	☐ *	
11	Do you require O2 supplementation?	☐	☐ *	
12	Restlessness, concentration problems, tiredness	☐	☐	
13	Bladder or urological / gynaecological problems	☐	☐ *	
14	Vomiting, nausea, flatulence	☐	☐ *	
15	Back problems, joint problems	☐	☐ *	
16	Do you have difficulty climbing stairs?	☐	☐	
17	Do you need a wheel chair?	☐	☐	
18	Are you independent?	☐	☐	
19	If you are in need of care, please explain briefly.			
20	Do you have a drainage or bandages?	☐	☐	
21	Allergies, hay fever	☐	☐ *	
22	Psychological problems	☐	☐	
23	Do you follow a special diet?	☐	☐ *	
24	Osteoporosis (If yes, do you take medications? Bisphonates?)	☐	☐ *	
25	Unusual reaction to injections or medication (Penicillin, Iodide, anaesthetics etc.)	☐	☐ *	
26	Increased bleeding tendency	☐	☐	
27	Epilepsy	☐	☐	
28	HIV	☐	☐	
29	Hepatitis	☐	☐	
30	Liver disease, diabetes	☐	☐ *	
31	Women: are you pregnant?	☐	☐	
32	Do you smoke? If so, how often?	☐	☐ *	
33	Do you dring Alkohol? if so, how often?	☐	☐ *	

If yes, which ones or how many? (list under comments.)en)

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☐ Others, please describe:

Date: Signature: