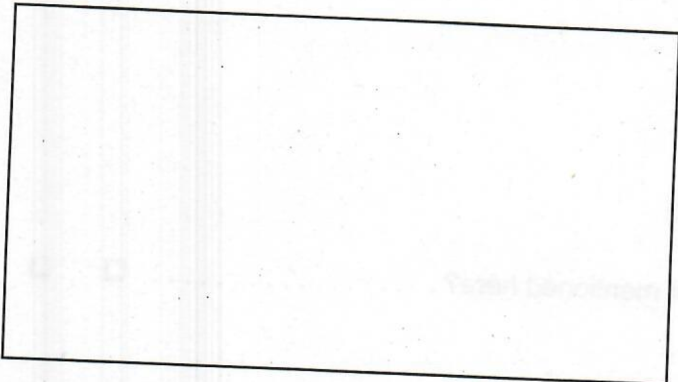

Praxis für Allgemeinmedizin
Dr. med. Udo Richter
Facharzt für Allgemeinmedizin / General Practitioner

Akupunktur / acupuncture • Chirotherapie / chiropractic
Naturheilverfahren / naturopathic and complementary medicine
Rettungsmedizin / emergency medicine

Surname ....
First name ....
Date of birth .... **job:** ....
Marital status / children: .... **e-mail:** ....
Phone/mobile/cellphone: ....
....

Patient questionnaire

The answers to the following questions are of great importance for your treatment.
Please be so kind and answer all questions completely, regardless wether you consider them important for your current problem or not.
If you have any questions, feel free to contact the doctor. Of course your information will be kept confidential!

Please describe your present problems:
....
....
....

✍ **Please mark whether the following topics are applicable to you:**

		Yes	No
1.	Did any accident occur at work or at school?	☐	☐
2.	Has there been any change in your general health within the past year or did you loose weight significantly?	☐	☐
3.	Have you been in medical treatment lately?	☐	☐
4.	Do you take any medical drugs regularly? (See also the following page)	☐	☐
5.	Are there any allergy tendencies (incompatibilities)? ☐ medical drugs.................. ☐ foods.................. ☐ pollen.................. ☐ others	☐	☐
6.	Do you have any heart disease, cardiac defect or any complaint in the region of the heart?	☐	☐
7.	Do you have hypertension? (Do you know your blood pressure? ....)	☐	☐
8.	Do you have a cardiac pacemaker?	☐	☐
9.	Did you or do you have any respiratory ailment or lung disease (asthma, tuberculosis)?____	☐	☐
10.	Are you diabetic?	☐	☐
11.	Do you have any blood coagulation deficiencies or prolonged bleeding at injuries?	☐	☐
12.	Do you have any thyroid gland disease? hyperfunction ☐ hypofunction ☐	☐	☐
13.	Do you or did you have any nephropathy?	☐	☐
14.	Do you or did you have any liver disease (icterus, hepatitis A, - B, - C)?	☐	☐
15.	Did you have any blackout, faint or seizure (apoplexy, epilepsy)?____________	☐	☐
16.	Do you have a glaucoma?	☐	☐
17.	Did you have an acute rheumatic fever?	☐	☐
18.	Do you have any infectious disease?	☐	☐
19.	Have you ever been tested for HIV (AIDS)?	☐	☐

20. Do you tend to ❑ constipation ❑ diarrhoea?

21. Do you suffer from any discomfort or disease not mentioned here? .... ❑ ❑

22. What operations have you had? When?

....

....

23. What medications do you take at present?

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

24. weight..................................kg / height...cm
Any loss in weight?.................kg / any increase of weight?..............................kg
Since when?.............................

25. Do you smoke? ..../ How much? ....
26. How much alcohol do you drink?..
27. Which inoculations have you had?...
28. Females: Are you pregnant or is there any possibility of being pregnant? ❑ ❑
29. You come - for consultation ❑ ❑
- for emergency treatment ❑ ❑
- because of referral of .... ❑ ❑

30. Have you been in dental treatment last year? ❑ ❑

Your remarks, complements, requests: ....

Date **Signature**