# Medical History

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**Dear Patients,**

We are pleased to welcome you as a new patient in our modern family practice. To get to know you and your wellbeing/ health better, we kindl ask you to fill out the following questionnaire. Thank you.

Name, Surename

Cate of Birth dd.mm.yyyy)

Height: cm Current Weight: kg Career:

☐ Married/ co-living ☐ Single ☐ Divorced ☐ Widowed

☐ Retirement Children ☐ No ☐ yes ☐ adult

**Do you smoke?** ☐ No ☐ yes How many cigarettes daily? Since when do you smoke?

☐ I´ve stopped since

Is there any history of any of the following illnesses in your family? (Please mark)

☐ KHK/ Heart attacks ☐ Asthma

☐ High blood pressure ☐ Thrombosis ☐ Pulmonary Embolism

☐ Cancer ☐ Stroke(s) ☐ Other

Do you have any allergies ? ☐ no ☐ yes (please mark)

☐ Pet hair/ Dust ☐ Food

☐ Pollen/ Grass ☐ Medications?

Do you have or have you had any of the following illnesses? (please mark)

☐ High blood pressure ☐ Migraines ☐ Stroke ☐ Heart attacks

☐ Asthma ☐ COPD ☐ Diabetes ☐ Canser ☐ Hepatitis and/or HIV

☐ Thyroid Disease ☐ Thrombosis ☐ Pulm. Embolism ☐ Other:

Do you take any medicines? ☐ No ☐ yes, please bring a list of all medication

Do you take any dietary supplements/ herbal medicines/ herbal teas ? ☐ no ☐ yes

What do you take:

What is your diet? ☐ Omnivore ☐ Vegetarian ☐ Vegan ☐ Other (such as fasting, or other diets

How much water do you drink daily? ☐ max. 1L ☐ about 1,5 ☐ about 2L ☐ mehr als 2L

Do you drink coffe? ☐ No ☐ yes How many cups?

Do you drink alcohol? ☐ No ☐ yes How often? ☐ occasionally ☐ weekly ☐ daily ☐ rarely

Is your defecation ☐ regular ☐ irregulare ☐ daily ☐ 2-3x a week ☐ less than 2x a week

☐ solid ☐ more liquid ☐ difficult ☐ painful ☐ forced

Do you need to urinate at night? ☐ No ☐ yes How ofent?

Do you have struggle to sleep? ☐ no ☐ yes ☐ when trying to fall asleep ☐ sleeping through the night

Have you had any surgeries (please mark):

☐ Appendix removal ☐ Gallbladder removal ☐ Joint replacement

☐ Tonsil removal ☐ Thyroid operation ☐ Radiation or chemotherapy

☐ Pacemaker/ Defilllibrator ☐ Cardiac catheter ☐ Other:

Do you have a vaccination certificate? ☐ No ☐ yes When were you last vaccinated?

If you have a vaccination certificate ID, please bring it to your next appointment so we can verify your vaccination status.

How would you asses your current physical performance?
(1: very low, 10: very high)

How often do you feel stressed in everyday life?
(1: hardly, 10: very often)

How resilient do you consider yourself?
(1: hardly, 10: very high)

Do you partake in any physical activity in the fresh air? ☐ No ☐ yes

☐ Fitness ☐ Walking

☐ Cycling ☐ Dancing

☐ Hiking ☐ Other:

Notes:

Date/ Signature