EXPERTMEDICAL

Privatpraxis für
Urologie,
Sexualmedizin &
Innere Medizin.

Medical History Questionaire

Please do not empty your bladder prior to examination!

Name ____________ **Surname** ______________ **Gender** m / f / div. **Date of birth** ______________

Adress
street, number:_________________
postcode:___________ **city:** ________________

Telephone ___________________ **E-mail** ___________________

Profession ________________ **general practitioner** ___________________

Do you smoke? yes / no **Height (cm)** _________ **Weight (Kg)** _________

I hereby declare that the information given is correct:

____

Date/ Patient`s signature

Information on the processing of your personal data

Our practice uses an IT system for your patient file, billing, accounting, as well as for communicating with other health professionals where these are involved in your patient care and withpublic authorities based on their legal obligations.
All information collected in the context of your patient file.
Further information on the processing of your personal data and your rights is available from the secretary`s office. This detailed information is available in several languages.

Preexisting conditions?

Infectious diseases:

	yes	when ?
Scarlet fever	☐	__________
Rheumatic fever	☐	__________
Mumps	☐	__________
Rubella	☐	__________
Tuberculosis	☐	__________
Hepatitis Type A	☐	__________
Hepatitis Type B	☐	__________
Hepatitis Type C	☐	__________
sexually transmitted diseases	☐	__________
HIV, AIDS	☐	__________

Other diseases:	**yes**
Angina pectoris, coronary artery disease	☐
Heart attack	☐
Arrhythmia	☐
High blood preassure	☐
Lung diseases, e.g. asthma bronchial	☐
Circullatory disorders in the legs e.g. intermittent claudication, varicose veins	☐
Circulatory disorers in the head, e.g. stroke	☐
Diabetes mellitus	☐
Elevated blood lipids, lipid metabolic disorder	☐
Gout	☐
Gastrointestinal problem, e.g. heartburn, ulcers	☐
Gall bladder diseases	☐
Malignant diseases, cancer or tumors	☐
Bladder diseases	☐
Prostate diseases	☐
Urinary stones	☐
Kidney diseases	☐
Mental diseases, psychosis	☐
Thyroid disease	☐
Epilepsy	☐
Lipid metabolic disorder	☐

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Have you ever had surgery? Where? When?

____

____

Which medications do you take regularly?

____

____

Any known allergies against medications?

____

For female patients:

Are you pregnant? **no / yes**

Do you take contraceptives? **no / yes** **Which?________________**

Date of the last menstruation : ________________