Dr. med. Nicole Fornoff
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Allgemeinmedizin
Naturheilverfahren
Reisemedizin
Arbeitsmedizin

Hausärztliches-Zentrum Poing
Ihre fachärztliche Rundum-Betreuung

Medical history

Dear patient,

please fill out the following questionnaire as complete as possible. Your answers will help us to get to know you better. Of course, your answers will be handled confidential.

Surname: ______________________ First name: ______________________

Date of birth: ____________

Address: ____

Telephone number: ____

E-mail: ____

Occupation: ____

Marital status: ___________Height: ___________ Body weight: ____________

Do you smoke? No ☐ Yes_______ Cigarettes per day

What are your actual complaints?

____

Do you have or have you had any of the following diseases?

	No	Yes	Which?
Disease of the thyroid gland	☐	☐	______
Lung infection; pleurisy; disease of the bronchi	☐	☐	______
Asthma, Hay fever	☐	☐	______
Allergies	☐	☐	______
Skin disease	☐	☐	______
Stroke	☐	☐	______
Circulation disorder	☐	☐	______
Heart disease	☐	☐	______
Vascular suffer/Varicose veins/Thrombosis	☐	☐	______
Gastro-intestinal disease	☐	☐	______
Liver-bile disease	☐	☐	______
Diseases of the kidney or abnormalities	☐	☐	______
Prostate disease	☐	☐	______
Disease of the female breast / female abdomen	☐	☐	______
Infectious diseases (like HIV, Hepatitis)	☐	☐	______

Please turn around

	No	Yes	Which?
Eye disease	◻	◻	________
Nerve suffers / convulsive seizures	◻	◻	________
Diabetes	◻	◻	________
Gout	◻	◻	________
Rheumatism / Soft tissue rheumatism	◻	◻	________
Other diseases of the joints or spine	◻	◻	________
Anemia / blood disease	◻	◻	________
Cancer	◻	◻	________
Other diseases or injuries?	◻	◻	

____

____

____

Have you had any surgery? If so, which?

____

____

What do you think is important for us to know about you? ______________________

____

____

____

Do or did you take birth control pill? ________

Are you pregnant? ________

Do you have children? ____________ Age of the children? ____________________

Have you had a miscarriage / stillbirth / pregnancy abort?

____

Do you take medications regularly? If so, which?

____

____

____

Does a family member have any disease from above? If so, which?

____

____

Thank you for your support!

Date ____________________ Signature: ________________________________