Privatpraxis für ganzheitliche Medizin und Prävention
Dr. med. Sigrid Hübschmann

Medical History

Please fill out this questionnaire before consulting the doctor.
If you have any questions, never mind to ask us.

Name, Surname: ____________________ **Date of birth:** ____________

male: ☐ **female:** ☐ **Marital status:** ☐ single ☐ married ☐ divorced ☐ widowed

street: ____________________ postal code: ________ city: ____________

job: ____________________ phone home: ____________

employed at: ____________________ mobile phone: ____________

☐ self-employed

Did you have the following childhood diseases?

Measles (Masern)	yes ☐	no ☐
Rubella (Röten)	yes ☐	no ☐
Chicken pocks (Windpocken)	yes ☐	no ☐
Mumps (Mumps)	yes ☐	no ☐
Scarlet (Scharlach)	yes ☐	no ☐

Did you have surgery?

Appendix (Blinddarm)	yes ☐	no ☐
Tonsils (Mandeln)	yes ☐	no ☐

Other surgery / injuries / accidents / scars:

____

____

Pre-existing conditions?

Condition	yes	no
Elevated blood pressure / hypertonia (Bluthochdruck)	☐	☐
Diabetes (Blutzuckerkrankheit)	☐	☐
Gastric disease (Magenerkrankung)	☐	☐
Tumor disease (Tumorerkrankung)	☐	☐
Kidney disease (Nierenerkrankung)	☐	☐
Skin disease (Hautkrankheit)	☐	☐
Hypercholesterolemia (Fettstoffwechselstörung)	☐	☐
Gout (Harnsäurestoffwechsel-Störung / Gicht	☐	☐
Rheumatic / joint disease (Gelenk Rheuma)	☐	☐
Tuberculosis (Tuberkulose)	☐	☐
Aids	☐	☐
Liver disease (Leberentzündung)	☐	☐
Asthma	☐	☐
Heart disease (Herzkrankheit)	☐	☐
Mental disease (psychische Erkrankung)	☐	☐
Epilepsy (Anfallsleiden)	☐	☐

Other: ______________________________

____

Do you suffer from allergies?

Allergy	yes	no
Penicilline (Penicillin)	☐	☐
Aspirine (Aspirin – Acetylsalicylsäure)	☐	☐
Hay fever/ pollen (Blütenstaub)	☐	☐
Animal hair (Tierhaare)	☐	☐
Dust mites (Hausstaubmilben)	☐	☐
Food (Nahrungsmittel)	☐	☐
Metal	☐	☐

Other: ______________________________

____

Psych. illness / stress? yes ☐ no ☐

Other pre-existing conditions / intoxications (sprays, exhaust fumes, amalgam, etc.) yes ☐ no ☐

Do you have a family history of:

Hypertonia (Bluthochdruck)	yes ☐	no ☐
Diabetes (Blutzuckerkrankheit)	yes ☐	no ☐
Hypercholesterolemia (Fettstoffwechsel)	yes ☐	no ☐
Heart attack (Herzinfarkt)	yes ☐	no ☐
Asthma	yes ☐	no ☐
Cancer (Krebs)	yes ☐	no ☐

Please specify ______________________________

Other: ______________________________

____

Do you smoke?

If yes, how many cigarettes a day? __________ since __________ years

Do you consume alcohol?

If yes, how often? daily ☐ 1-2 x per week ☐ 3-4 x per week ☐

What kind of alcohol? ______________________________

Do you take any medication regulary?

Please specify ______________________________

____

Body height (in cm): ____________________

weight (in kg): ____________________

Do you have vaccinations against:

Tetanus	yes	☐	no	☐
Diphtheria (Diphterie)	yes	☐	no	☐
Polio	yes	☐	no	☐
Tuberculosis (Tuberkulose)	yes	☐	no	☐
Mumps	yes	☐	no	☐
Hepatitis A	yes	☐	no	☐
Hepatitis B	yes	☐	no	☐
Rubella (Röteln)	yes	☐	no	☐

☐ not known / no Information -> Please hand in your vaccination certificate on your next appointment. Thank you!

Do you wear glasses?

If yes, how many diopters?: ____________________

Thank you for taking the time to answer our questionnarie. Your information is treated as strictly confidential.

____________________ ____________________

Date, city Signature of patient Signature and stamp of practice