

Practice Friederike Schönburg-Liedtke

Medical History Questionnaire

Personal details (Persönliche Daten)

Last name, first name: _____

Date of birth: _____

Gender: male female diverse

Height: _____ cm Weight: _____ kg

Medications: _____

Allergies: _____

Occupation: _____

E-mail _____

Native language :

Lifestyle habits (Lebensgewohnheiten)

Smoking: no yes, number: _____ per day Since: _____ years

Drug use: no yes

Alcohol consumption: no yes, amount: _____ beverage:

Pre-existing conditions - please tick as applicable (Vorerkrankungen)

- High blood pressure
- Diabetes mellitus
- Eye conditions
- Kidney conditions
- Thyroid conditions
- Lung conditions
- Seizure disorder (e.g., epilepsy)

- Other: _____
- Surgeries and cancer history (OP und Krebserkrankungen)

Family history (Familienanamnese)

- Cancer
- Diabetes
- High blood pressure
- Stroke
- Heart attack
- Lung conditions
- Osteoporosis
- Elevated lipid levels
- Mental illness

Mental health (Psychische Gesundheit)

- Depression
- Anxiety disorders
- Panic attacks
- Borderline personality disorder
- Persistent sadness
- Low motivation / lack of drive
- Avoidance of social contacts

Pain (Schmerzen)

Body part(s): _____

Intensity (0 = no pain, 10 = worst imaginable pain):

0 1 2 3 4 5 6 7 8 9 10

Character - please tick as applicable:

- Stabbing
- Dull
- Radiating
- Wave-like
- With movement
- At rest
- Pulling

For women (Für Frauen)

No children: yes no

Children: number: _____

Pregnancies: number: _____

Terminations of pregnancy: number: _____

Miscarriages: number: _____

Pregnancy complications:

- Preterm birth
- Stillbirth
- High blood pressure during pregnancy
- Gestational diabetes
- Multiple pregnancy

Menopause: yes no

Endometriosis: yes no unclear

Menstrual cramps: yes no

Diet (Ernährung)

- Omnivore
- Vegetarian
- Vegan
- Other: _____

Doctor's notes (Arztvermerke)

Patient signature: _____

Date: _____