TIM OLIVER
FLETTNER

MEDICAL HISTORY QUESTIONNAIRE

Please fill in this form before the doctor's consultation (visit).
If you have any questions, feel free to ask we are happy to help.

PERSONAL DATA

Surname, First Name: _____ Date of Birth: _____

☐ Male ☐ Female Height: _____ Weight: _____

Address: _____

E-Mail: _____

Mobile no.: _____ Phone no.: _____

HAVE YOU HAD ANY OF THE FOLLOWING CHILDHOOD DISEASES?

Measles	☐ yes	☐ no	Mumps	☐ yes	☐ no	Chicken Pox	☐ yes	☐ no
Rubella	☐ yes	☐ no	Scarlet Fever	☐ yes	☐ no			

PRE-EXISTING CONDITIONS

Epilepsy	☐ yes	☐ no	Respiratory Diseases	☐ yes	☐ no
Blood clotting disorder	☐ yes	☐ no	Diabetes Mellitus	☐ yes	☐ no
Heart and/or circulatory disease	☐ yes	☐ no	Heart Failure	☐ yes	☐ no
Deviation of Heart/Cardiac Rhythm	☐ yes	☐ no	Pacemaker	☐ yes	☐ no
Hypertension	☐ yes	☐ no	Hypertension	☐ yes	☐ no
Liver Disease	☐ yes	☐ no	Disorders of the Stomach	☐ yes	☐ no
Kidney Disease	☐ yes	☐ no	Osteoporosis	☐ yes	☐ no
Mental Illness	☐ yes	☐ no	Rheumatoid Arthritis	☐ yes	☐ no
Thyroid Disease	☐ yes	☐ no	Immunodeficiency	☐ yes	☐ no
Uric acid metabolism disorder	☐ yes	☐ no			
Disease with Tumour Formation (If yes, which type?)	☐ yes	☐ no	_____		

HAVE YOU HAD SURGERY?

☐ yes ☐ no If yes, what type and when? _____

DO YOU SUFFER FROM ALLERGIES?

☐ yes ☐ no If yes, please give details. _____

ARE YOU PREGNANT?

☐ yes ☐ no How many weeks? _____

Tim Oliver Flettner
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FAMILY HISTORY

High Blood Pressure	☐ yes ☐ no	Fat Metabolism	☐ yes ☐ no
Heart Attack	☐ yes ☐ no	Uric acid metabolism disorder	☐ yes ☐ no
Stroke	☐ yes ☐ no	Kidney Diseases (e.g. Kidney Stone)	☐ yes ☐ no
Diabetes Mellitus	☐ yes ☐ no	Asthma	☐ yes ☐ no
Thyroid Disease	☐ yes ☐ no	Allergies	☐ yes ☐ no
Cancer (If yes, which type?)	☐ yes ☐ no		

DO YOU SMOKE OR DRINK ALCOHOL?

Smoke ☐ yes ☐ no If yes, how many cigarettes a day? _____

Alcohol ☐ yes ☐ no If yes, how often? ☐ daily ☐ from time to time ☐ _____

MEDICATION

Name	mg/stroke	morning/noon/evening

I AM VACCINATED AGAINST:

Tetanus	☐ yes ☐ no	Pertussis	☐ yes ☐ no	Rubella	☐ yes ☐ no
Diphteria	☐ yes ☐ no	Measles	☐ yes ☐ no	Hepatitis A	☐ yes ☐ no
Polio	☐ yes ☐ no	Mumps	☐ yes ☐ no	Hepatitis B	☐ yes ☐ no

SOCIAL STATUS

☐ Single ☐ Married ☐ Divorced ☐ Widowed
☐ Living Alone ☐ In a Parnership ☐ With Husband ☐ With Wife

Children ☐ yes ☐ no

☐ Boy Number: _____ Date of Birth: _____
☐ Girl Number: _____ Date of Birth: _____

☐ Secondary School ☐ Intermediate School Certificate ☐ University of Applied Sciences ☐ High School ☐ University Degree

Profession: _____

HOW DID YOU HEAR ABOUT US?

☐ Family/Friends ☐ Internet ☐ Advertisement ☐ Other _____

Thank you for taking the time to answer all the questions. Your responses will be treated, as strictly confidential and will not be passed on to third parties.

Date, Place | Patient's Signature | Signature and Stamp of Practice

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