RUHRRADIOLOGIE

Questionnaire for your medical history

Dear Patient!

The information on your person and medical history on this patient questionnaire are used to clarify any complaints that may be present. We ask for the most complete and accurate answers to the questions. In this way, we can specifically discuss individual problems with you in the preliminary medical consultation and are in a position to coordinate planned examinations with your specific medical history.

Please mark the appropriate box clearly.

Thank you for your help!

Personal

Surname/name _____ Date of birth _____

Street/nr. _____

Post code/place _____

Phone number _____ Mobile number _____

E-Mail _____

Occupation _____

Do you currently have any complaints? If yes, which?

_____

_____

_____

_____

_____

_____

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		Yes	No
1	typhoid / paratyphoid fever	☐	☐
2	tuberculosis	☐	☐
3	glaucoma / increased intraocular pressure	☐	☐
4	nasal sinusitis	☐	☐
5	thyroid diseases	☐	☐
6	pneumonia, bronchitis	☐	☐
7	asthma, hay fever	☐	☐
8	allergic reaction	☐	☐
9	high blood pressure	☐	☐
10	stroke, paralysis	☐	☐
11	heart attack	☐	☐
12	other heart diseases	☐	☐
13	varicose veins, hemorrhoids, thrombosis	☐	☐
14	stomach ulcer	☐	☐
15	constipation, diarrhea	☐	☐
16	jaundice, liver disease	☐	☐
17	gallstones	☐	☐
18	kidney disease, bladder disease	☐	☐
19	diseases of the prostate	☐	☐
20	difficulty urinating	☐	☐
21	diseases of the female abdominal organs	☐	☐
22	diseases of the female mammary gland	☐	☐
23	irregular menstrual period	☐	☐
24	skin diseases	☐	☐
25	nervous complaints, nervous breakdown	☐	☐
26	lumbago, sciatica, herniated disc	☐	☐
27	epilepsy		
28	diabetes	☐	☐
29	increased cholesterol level	☐	☐
30	gout	☐	☐
31	rheumatism	☐	☐
32	other diseases of the joints or spine	☐	☐
33	broken bones, accidents, war injuries	☐	☐
34	anemia, blood disorders		
35	cancer	☐	☐
36	cancer	☐	☐
37	other diseases, if yes, which?	☐	☐

_____

_____

38	Are you pregnant?	☐	☐
39	visual defect, hearing disorder	☐	☐

		Yes	No
40	Have you ever had surgery?	☐	☐
41	When was your last X-ray?	☐	☐
42	Do you take medication on a regular basis?	☐	☐
43	Do you regularly drink alcoholic beverages?	☐	☐
44	Do you smoke or did you smoke?	☐	☐
	If so, how much per day? Since when?		

_____

_____

41	Have you lost more than 5 kg within the last 12 months?	☐	☐

Did the following diseases occur in your family?

45	high blood pressure/stroke?	☐	☐
46	heart attack?	☐	☐
47	diabetes?	☐	☐
48	adipositas/overweight?	☐	☐
49	gallstones, kidney stones, bladder stones?	☐	☐
50	cancer?	☐	☐
	If yes, where?		

_____

_____

51	Any other diseases?	☐	☐
	If yes, which?		

_____

_____