MEDICAL HISTORY QUESTIONNAIRE

GASTRO ENTEROLOGIE FRIEDRICHSHAIN

Dear patient,

We kindly ask you to answer the following questions about your medical history as carefully and accurately as possible. This will help us in addressing your complaints and enable us to prevent possible risks during treatment. All information is voluntary and, of course, is subject to strict medical confidentiality.

GENERAL INFORMATION

Name: ..... First name: .....

Date of birth: ..... Marital status: .....

Phone: ..... Mobile: .....

E-mail: ..... Insurance: .....

Emergency contact (name, mobile number): .....

Family doctor: ..... Referring doctor: .....

Height (cm): ..... Weight (kg): .....

Doctor to whom the histological findings are to be sent should tissue samples (biopsies) be taken:

.....

MEDICATION

Which medication do you take (regularly)? Please list **all** medications that you are currently taking.

.....

.....

PRE-EXISTING DISEASES/CONDITIONS

- High blood pressure yes ☐ no ☐
- Coronary heart disease yes ☐ no ☐
- Asthma/respiratory and lung diseases yes ☐ no ☐
- Diabetes yes ☐ no ☐
- Liver diseases (e.g. hepatitis) yes ☐ no ☐
- Metabolic diseases yes ☐ no ☐
- Seizure disorders/epilepsy yes ☐ no ☐
- Blood coagulation disorder yes ☐ no ☐
- Kidney diseases yes ☐ no ☐
- Heart valve defects/surgery/pacemaker yes ☐ no ☐
- Other infectious diseases (e.g. AIDS/HIV, tuberculosis) yes ☐ no ☐
- Other diseases yes ☐ no ☐ If yes, which ones? .....
- Do you currently have or have you ever had cancer? yes ☐ no ☐
  If yes, which form, since when, of which part of the body? .....
- Have you suffered from any serious previous illnesses or have had an operation in the abdominal cavity? yes ☐ no ☐
  If yes, which ones? When? .....

Please also fill in the reverse side • page 1

- Is there a family history of cancer? yes ☐ no ☐
  If yes, which ones? .....
- Have you ever had a gastroscopy or colonoscopy? yes ☐ no ☐
  If yes, when/which one? .....

ALLERGIES / INTOLERANCES

- Local anaesthesia/injections yes ☐ no ☐
- Painkillers yes ☐ no ☐
- Antibiotics yes ☐ no ☐
- Other yes ☐ no ☐ If yes, which? .....
- Peanuts yes ☐ no ☐
- Soya yes ☐ no ☐
- Have you ever experienced any intolerances during operations so far? yes ☐ no ☐

I SUFFER FROM

- Abdominal pain yes ☐ no ☐ If yes, where? ☐ Upper abdomen ☐ Lower abdomen
- Flatulence yes ☐ no ☐
- Constipation yes ☐ no ☐
- Loss of appetite yes ☐ no ☐
- Do you smoke? yes ☐ no ☐ If yes, how much? .....
- Do you drink alcohol? yes ☐ no ☐
  If yes, which kind, how frequently and how regularly? .....
- Diarrhoea yes ☐ no ☐
- Blood in the stool yes ☐ no ☐
- Weight loss yes ☐ no ☐
- Have you travelled abroad? yes ☐ no ☐
  When, where? Have you travelled to the tropics? .....

OTHER COMPLAINTS

- Cardiovascular yes ☐ no ☐
- Musculoskeletal system yes ☐ no ☐
- Snoring yes ☐ no ☐
- Respiratory tracts yes ☐ no ☐
- Sleeping disorders yes ☐ no ☐
- Fainting spells yes ☐ no ☐
- I am free of symptoms/I have no physical complaints yes ☐ no ☐

SELF-EVALUATION

- Please describe your physical complaints in your own words:

  .....
- When did these complaints start?

  .....
- What leads to an improvement / worsening of the physical complaints?

  .....
- What do you think might be the cause of the complaints?

  .....

Berlin, (date) ..... Signature .....