Pulmologische Praxis am Hassel
Dr. Susanne Riese, Boelsche Straße 1a, 39104 Magdeburg, Tel. 0391/5410465

Patient Questionnaire / Medical History

Dear patient, we are pleased that you came to our practice. So that we can best adapt the treatment to your health condition, we ask you to fill out this questionnaire to the best of your knowledge. Take your time to answer the following questions. If a question is incomprehensible to you, leave it open for now. One of the employees will be happy to help you answer it later. Please give me the completed, signed form upon initial contact. Of course, your information will be treated as strictly confidential in accordance with the GDPR and will not be passed on to anyone!

Name / First Name :	**Adress:**
Phone / Mobile :	**Birth Date :**
Height :	**Body Weight:**

What illnesses do you know of?

No Illnesses	**Yes □**	**No □**			
Diabetes	**Yes □**	**No □**	**Dizziness attacks**	**Yes □**	**No □**
Tendency to bleed	**Yes □**	**No □**	**Heart disease**	**Yes □**	**No □**
High blood pressure	**Yes □**	**No □**	**Heart attack**	**Yes □**	**No □**
Cholesterol too high	**Yes □**	**No □**	**Stroke**	**Yes □**	**No □**
Stomach disease	**Yes □**	**No □**	**Gout**	**Yes □**	**No □**
Kidney disease	**Yes □**	**No □**	**Rheumatism**	**Yes □**	**No □**
Intestinal disease	**Yes □**	**No □**	**Asthma, chronic Bronchitis**	**Yes □**	**No □**
Liver disease	**Yes □**	**No □**	**Seizure disorder**	**Yes □**	**No □**
Thyroid	**Yes □**	**No □**	**mental Illness**	**Yes □**	**No □**
Tuberculosis	**Yes □**	**No □**	**Skin diseases**	**Yes □**	**No □**
Cancer diseases	**Yes □**	**No □**	**Allergies**	**Yes □**	**No □**

Note according to the General Data Protection Regulation: The "Information on the Collection of Personal Data" can be viewed in practice.

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What specialist medical treatment do you regularly receive?

Pulmonologist □ Orthopedist □ Urologist □ Cardiologist □

Neurologist □ Hematology □ more □ _____

Which of these operations have you had in the last few years?

No Operations □ Heart Surgery □ Breast Surgery □

Do you regularly take Medication ? **Yes** □ **No** □

If yes, which ones and how often?

_____

_____

_____

_____

Questions about X-ray Examinations

When was your last Chest X-ray? _____

Do you wear a Pacemaker? Yes □ No □

Do you wear body jewelry (piercing or similar on your upper body)? Yes □ No □

Do you have metallic Implants in your upper Body? Yes □ No □

Only for female Patients!

Are you pregnant or is there a probability? Yes □ No □

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What illnesses are known in your Family? (Mother, Father, Siblings, Children)

Heart disease/ Heart attack	**yes □**	**what kind / with whom?**
Respiratory disease (Asthma etc.)	**yes □**	**what kind / with whom?**
Lung disease (Embolism, etc.)	**yes □**	**what kind / with whom?**
Allergies (hay fever or Similar)	**yes □**	**what kind / with whom?**
Cancer (Lung cancer or Similar)	**yes □**	**what kind / with whom?**
Blood diseases (propensity to thrombosis or similar)	**yes □**	**what kind / with whom?**
Other Diseases	**yes □**	**what kind / with whom?**

Have you had the following Procedures in the last 12 Months?

Vascular surgery. yes □ Uterus surgery. yes □ Cancer surgery. yes □

Tonsil surgery. yes □ Thyroid surgery yes □ Appendix surgery yes □

Other surgeries Yes □_____

Date _____ **Signed** _____

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