CHECKUP BERLIN

## Medical History Questionnaire

To help us assess your medical history, please answer the following questions.
We will discuss them with you in detail during your check up appointment.
Of course all information will be kept confidential.

Thank you,
The Checkup Berlin Team

Name……
Birthday ……

### 1. General questions

| | | | |
|---|---|---|---|
| 1.1 | Have you ever been admitted to hospital? | O no | O yes |
| 1.2 | Did you ever need surgery? | O no | O yes |
| 1.3 | Do you have a vaccination record? | O yes | O no |
| 1.4 | Did you travel to exotic destinations? | O no | O yes |
| 1.5 | Do you suffer from food intolerances? | O no | O yes…… |
| 1.6 | Do you have any allergies? | O no | O yes…… |
| 1.7 | Are you allergic to certain medications? | O no | O yes…… |
| 1.8 | Do you take blood-thinning medication? (ASS, Coumadin) | O no | O yes…… |
| 1.9 | Have you ever had a colonoscopy? | O yes | O no |
| 1.10 | Have you ever had skin cancer screening? | O yes | O no |
| 1.11 | Have you had a medical check-up before? | O yes | O no |
| 1.12 | Is there a history of cancer in your family? | O no | O yes |
| 1.13 | Have you had a mammography? | O yes | O no |
| 1.14 | Do you smoke or have you ever smoked in the past? | O no | O yes |

| | | | |
|---|---|---|---|
| 1.15 | Do you drink alcoholic beverages on a regular basis? | O no | O yes |
| 1.16 | Do you exercise? | O yes | O no |
| 1.17 | Are you vegetarian? | O no | O yes |
| 1.18 | How tall are you? | . . . . . cm | |
| 1.19 | What is your weight? | . . . . . kg | |

2. Bones and Muscles

| | | | |
|---|---|---|---|
| 2.1 | Did you ever fall? | O no | O yes |
| 2.2 | Did you ever have a broken bone? | O no | O yes |
| 2.3 | Do you suffer from osteoporosis? | O no | O yes |
| 2.4 | Did you ever have a slow healing wound? | O no | O yes |
| 2.5 | Did you ever have a seizure? | O no | O yes |
| 2.6 | Do you have varicose veins? | O no | O yes |
| 2.7 | Are you suffering from chronic pain? | O no | O yes |
| 2.8 | Do you experience frequent headaches? | O no | O yes |

3. Sense Organs

| | | | |
|---|---|---|---|
| 3.1 | Do you suffer from glaucoma? | O no | O yes |
| 3.2 | Are you wearing glasses or contact lenses? | O no | O yes |
| 3.3 | Are you hearing impaired? | O no | O yes |
| 3.4 | Do you ever experience numbness? | O no | O yes |

4. Heart and Circulation

| | | | |
|---|---|---|---|
| 4.1 | Have you ever had a heart attack? | O no | O yes |
| 4.2 | Have you ever had a stroke? | O no | O yes |
| 4.3/4.4 | Do you suffer from chest pain? | O no | O yes |
| 4.5 | Are you dizzy sometimes? | O no | O yes |
| 4.6 | Have you ever fainted? | O no | O yes |
| 4.7 | Do you have high blood pressure? | O no | O yes |
| 4.8 | Do you suffer from palpitations? | O no | O yes |
| 4.9 | Do your legs hurt when you are walking? | O no | O yes |
| 4.10 | Do you need to go to the bathroom at night? | O no | O yes |

5. Lungs

| | | | |
|---|---|---|---|
| 5.1 | Are you short of breath? | O no | O yes |
| 5.2 | Do you cough a lot? | O no | O yes |

| | | | |
|---|---|---|---|
| 5.3 | Do you suffer from asthma? | O no | O yes |
| 5.4 | Do you suffer from hey fever? | O no | O yes |
| 5.5 | Do you have /have you ever had tuberculosis? | O no | O yes |
| 5.6 | Do you snore? | O no | O yes |

6. Infections

| | | | |
|---|---|---|---|
| 6.1 | Have you ever had hepatitis or jaundice? | O no | O yes |
| 6.2 | Do you have an infectious/contagious disease? | O no | O yes |
| 6.3 | Do you often catch a cold? | O no | O yes |

Last name:.....

7. Hormones

| | | | |
|---|---|---|---|
| 7.1 | Do you suffer from diabetes? | O no | O yes |
| 7.2 | Do you suffer from a thyroid malfunction? | O no | O yes |
| 7.3 | Are you suffering from menopause symptoms? | O no | O yes |

8. Digestion

| | | | |
|---|---|---|---|
| 8.1 | Do you suffer from heartburn? | O no | O yes |
| 8.2 | Do you have problems going to the bathroom? | O no | O yes |
| 8.3 | Did you ever experience blood in your stool? | O no | O yes |
| 8.4 | Have you ever had black stool? | O no | O yes |
| 8.5 | Do you have other digestive problems? | O no | O yes |

9. Mental health

| | | | |
|---|---|---|---|
| 9.1 | Are you happy? | O yes | O no |
| 9.2 | Do you suffer from anxieties? | O no | O yes |
| 9.3 | Do you experience a loss of memory? | O no | O yes |
| 9.4 | Do you sleep well? | O yes | O no |

10. Please list any medications that you take on a regular basis.

11. Do you have special medical concerns or questions?

Date and Signature