



Patient Questionnaire / Anamnesis Sheet

Dear Patient, We are pleased that you have come to our practice. In order to be able to adapt the treatment of your state of health in the best possible way, we ask you to complete this questionnaire to the best of our knowledge. Take the time to answer the following questions should a question be incomprehensible to you. Later, one of the staff will be happy to assist you in answering this question. Please hand over the completed, signed sheet when you first contact me. Of course, your information will be treated strictly confidential according to the GDPR and will not be passed on to anyone!

Name :	Adress:
Phone / Mobil :	Date of Birth:
Height :	Weight:

What diseases are known to you?

No	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Dizziness	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bleeding.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	heart disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
high blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart attack.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cholesterol too high	Yes <input type="checkbox"/>	No <input type="checkbox"/>	stroke.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Stomach disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	gout.	Yes <input type="checkbox"/> No <input type="checkbox"/>
kidney disease.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	rheumatism	Yes <input type="checkbox"/> No <input type="checkbox"/>
bowel disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Asthma, chronic. Bronchitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
liver disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	seizure disorders	Yes <input type="checkbox"/> No <input type="checkbox"/>
thyroid.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	mental illness.	Yes <input type="checkbox"/> No <input type="checkbox"/>





Pulmologische Praxis Dr. med. Susanne Riese

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tuberculosis

Yes No

Skin diseases.

Yes No

cancer.

Yes No

Allergies

Yes No

Which type? _____

Which? _____

In which specialist treatment are you regularly?

Lung Specialist

Orthopedist

Urologist

Cardiologist

Neurologist

Haematologist

further: _____

What operations did you have?

No yes

Heart surgery surgery yes

Breast surgery yes

Vascular surgery yes

Uterine surgery yes

Cancer surgery yes

Almond- surgery yes

Thyroid surgery yes

Appendix operation yes

Other surgery: _____

Do you regularly take medication? If yes, which and how often? yes





Questions about the X-ray examination

When was your last x-ray examination on the chest (thorax)? _____

Do you carry a pacemaker? yes no

Do you wear body jewelry (piercing or similar on the upper body)? yes no

Do you wear metallic implants on the upper body? yes no

Only for female patients!

Are you pregnant or is the probability? yes no

Note According to DSGVO: The "Information on Collection of personal data" can be viewed in Practice