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Medical questionnaire

family name | first name | date of birth

phone number | cell phone number

email | height | weight | gender: f ☐ m ☐ d ☐ u ☐

Which illnesses are known to you?	Please list	yes	no
Cardiovascular disease *e.g. hypertension, coronary heart disease (CHD), arrhythmias, peripheral arterial disease (pAVK)*		☐	☐
Lung diseases *e.g. asthma, COPD, fibrosis*		☐	☐
Abdominal diseases *e.g. gastric ulcers, inflammatory bowel disease*		☐	☐
Metabolic diseases *e.g. diabetes mellitus, thyroid diseases*		☐	☐
Brain / mental disorders *e.g. stroke, epilepsy, migraine, depression*		☐	☐
Tumor diseases *If yes, which ones?*		☐	☐
Blood disorders / bleeding disorders *e.g. anemia, hemophilia, leukemia*		☐	☐
Infectious diseases *e.g. hepatitis, HIV, tuberculosis*		☐	☐
Other diseases *e.g. spinal problems, bone diseases*		☐	☐
Have you undergone any surgeries? *If yes, which ones and when?*		☐	☐
Do you regularly take medication? *If yes, which ones?*		☐	☐
Do you have any allergies? *If yes, which ones?*		☐	☐
Do you smoke (e.g. cigarettes / e-cigarettes / hookah / pipe)? *If yes, how much?*		☐	☐
Do you regularly consume alcohol?		☐	☐
Do you consume any other drugs?		☐	☐
Relevant family illnesses? *e.g. blood sugar, high blood pressure, CHD, malignant diseases*		☐	☐

Your information is of course subject to medical confidentiality and will be treated confidentially. The document will be properly destroyed after digitization.