patients questionnaire

surname:	date of birth:
first name:	street:
ZIP and city:	private phone:
mobile phone:	e-mail:
business phone:	fax:
profession / school class:	family doctor:

health insurance: private O public O additional O assistance O post O other:

for children bill to party:

Instruction:
Please fill in this questionnaire properly. If an example is fitting, it is sufficient to underline it. In other cases say it in your own words, please. You may take as long as you think you need.

Important! Your suggested to give a number from 1 to 10 (1 = least, 10 = extremely strong) to every symptom (e.g. headache 7) and in which year it appeared first.

Under which ailments do you suffer (3 main ailments)?
What diagnosis did the orthodox medicine make?

1.

2.

3.

Please have your actual medicine with you (in your daily dose) and also a panoramically X-Ray (OPG) of your complete teeth and jaw.

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What happened shortly before your ailment started (possibly activator)?
e.g. disease, grief, sorrow, fright, operation, eruption, medicine, a.s.o. ...

Which diseases are known in your family? (grandparents, parents, sisters and brothers)?
e.g. cancer, tuberculosis, depression, sexual transmitted disease, epilepsy, coronary disease, vain disease, stroke, asthma, diabetes mellitus, rheumatism, kidney stones, gallbladder stones, multiple sclerosis, gout, allergies, psoriasis, neurodermatitis

Were there strokes of fate in your family?

Which vaccinations did you get? Please have your vaccination certification book with you.
e.g. tuberculosis (BCG), polio, diphtheria, tetanus, haemophilias influenza (HIB), whooping cough (pertussis), measles, mumps, rubella, hepatitis, cholera, yellow fever, smallpox, flu, tick, a.s.o..

Were there reactions to the vaccination?
e.g. fever, cramps, restlessness, insomnia, changing in behaviour, a.s.o.

Which infection disease have you gone through?
measles, mumps, rubella, pertussis, chicken pox, scarlet, tetanus, polio, malaria, salmonellas, dysentery, Epstein-Barr-infection (mononucleosis), tropical disease, tuberculosis, borreliosis, tick-borne-encephalitis, meningitis, herpes, a.s.o.

Have ever been made a diagnosis of parasitical disease?

Were these or other disease been treated with antibiotics or cortisone?

If yes, was cortisone or antibiotics or both used?

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h e a d

Do you suffer with headaches? If yes,

How often? ________ rare, front-eyes-temporal-occipital-region:

____

in the morning / evening, on one side, left, right, both sides

activator: ________

what improves: ________

what deteriorates: ________

hair: loss of hair, circular, scales, since when? ________

eyes: conjunctivitis, cataract (grey star), short-sighted, long-sighted, eye-lenses, macula degeneration, laser-therapy, a.s.o.

ears: left, right, both sides, inflammation of the middle ear, deafness, pain, noises

teeth / jaw: please check off what is right:

problems with dentition?	○ yes	○ no	
wisdom-teeth extracted?	○ yes	○ no	which? ________
are there root-treated teeth?	○ yes	○ no	which? ________
gum bleeding?	○ yes	○ no	
are there death teeth?	○ yes	○ no	which? ________
sensible teeth to hot / cold?	○ yes	○ no	which? ________
were amalgam-fillings removed?	○ yes	○ no	when? ________
was amalgam lead out?	○ yes	○ no	

What was the medicine for leading out amalgam? ________

actual filling materials: ________

○ amalgam ○ gold ○ plastic ○ ceramics ○ Implant

nose: operations, hay fever, allergies to: ________

tonsils: operations, tonsil infections often as child / today, soar throat, bad breath

thyroid gland: hyper function, hypo function, enlargement, operations, Hashimoto

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b r e a s t / b e l l y

thymus gland:	ailments, operations, knots, cysts
Heart:	ailments, shooting, sensation of pressure, infarct, constriction, dysrhythmia, bypass
blood pressure:	date of last measurement? results ______
lungs:	bronchitis, cough often, alcohol is endured worse than earlier
gall bladder	Stones, colics, operations, sensation in the upper belly, incompatibility to fat
stomach:	sensation of fullness, loss of appetite, incompatibility to nourishing, heartburn
intestines:	infections, mycosis, hemorrhoids, appendix-operation, flatulence yes / no, smell
bowel movement:	daily, every 2. / 3. / 4. day, irregular, smells of ………………………., inclination to constipation, inclination to diarrhoea, stool, light, dark, evil-smelling, hard, lumpy, soft, greasy, paste like, feeling of not getting finished, bowel movement changing a.s.o., needs much paper / toilet brush
kidney / bladder:	kidney stones, inflammations often, shooting in the back often, right / left, bladder trouble irritant
urine:	much, less, often, not able to hold, foaming, smell of ______

a r m s / l e g s / b a c k / s k i n

arms:	injuries, pain, tennis elbow, prickle, cold hands, a.s.o.
legs:	injuries, pain, varices, danger of thrombosis, operations, cold feet, prickle, numbness, open wounds
back:	hardenings, rheumatism, pain cervical / thoracic / lumbar spine, lumbago, sciata, scoliosis, herniatic disc
skin / nails:	abscesses, pruritus, warts, fungi, onychia, eczema
	skin allergies to (crèmes a.s.o.): ______

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women's area

gynaecology: defluxion – none, heavy, white-yellow, making raw, dying clothes, pain, ovaritis, curettage, abort, birth

date: __________

abortions, tumours, cysts, myoma, fungi, sexual transmitted disease, a.s.o.

menses first menses? __________ last menses? __________

bleedings are bright, dark, cloddy, brown: __________

period is heavy, low, takes long: __________

interval of period: __________

ailments before – during – after period, which ones: __________

mid-cycle bleeding: __________

climacteric ailments: __________

do you use contraceptives? Which ones? __________ since when? __________

when was your last appointment at your genealogist? __________

men's area

prostate: enlarged, inflammations earlier, actual, ailment at urination, urination often during the night

when your last preventive check did up took place? __________

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generals

Where do you have scars? Important! With date of rise, also little ones

sleep: insomnia, awakening often at night (time of awakening ……….), problems falling asleep, speaking while sleeping, restlessness in the legs, night-sweat, hot feet, gnashing of teeth

dreams: horrible, pretty, in the morning, reflective, close to reality ____________

sports ____________ how often? ____________

nourishing craving for sweet, sour, piquant, salty, meat, eggs, fruits, nicotine, alcohol

animosity against, sweet, sour, piquant, salty, meat, alcohol

allergies to: ____________

Is your life based on certain principles for nourishing?

no / if yes, which? ____________

smoking: yes / no ____________ how many? ____________

alcohol: how often? ____________ what? ____________

drinking how much water, tee do you drink a day? ____________ litre ____________

pets do you or have you had pets? ____________

home-area: Which kind of electrical equipment do you use / have in your sleeping-room?

Do you use DECT telephones (cordless-telephone-standard)?

Did you have contact to dissolvers (thinner) chemicals or heavy metals in private or at work?

Which therapies were applied at you (biological e.g. oxygen, infusions, injections, medicine)?

How do you judge your state of bodily fitness at the moment (1= very good, 10 = very bad)? ________

How do you judge your psychological state at the moment (1= very good, 10 = very bad)? __________

Chronology of medical history (optional use back side or extra sheet of paper), please capture all disease and operations you have had and gone through.

____________ ____________

city, date signature

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