# Check-up Questionaire

Please answer the following questions and return the form before arriving for your check-up. Please send the survey by fax, email or regular mail. The information provided is strictly confidential.

## Demographic informations

First Name: _____

Surname: _____

Date of birth (dd.mm.yy): _____

Address: _____

Zip code: _____

City: _____

Country: _____

Telephone 1: _____

Telephone 2: _____

Mobile: _____

Fax: _____

Email: _____

# Check-up Questionaire

## Medical history

| Diagnosis | Symptoms | Yes | No | Details |
|---|---|---|---|---|
| Heart disease | | ☐ | ☐ | |
| | Infarction | ☐ | ☐ | |
| | Chronic heart failure | ☐ | ☐ | |
| | Cardiac arrhythmia | ☐ | ☐ | |
| | Chest pain | ☐ | ☐ | |
| Lung disease | | ☐ | ☐ | |
| | Cough | ☐ | ☐ | |
| | Asthma | ☐ | ☐ | |
| | Pulmonary embolism | ☐ | ☐ | |
| | Shortness of breath | ☐ | ☐ | |
| Kidney disease | | ☐ | ☐ | |
| Hypertension | | ☐ | ☐ | |
| | >140/90 mmHg | ☐ | ☐ | |
| | >160/90 mmHg | ☐ | ☐ | |
| Diabetes | | ☐ | ☐ | |
| | Insulin Therapy | ☐ | ☐ | |
| Stroke | | ☐ | ☐ | |
| Other vascular disease | | ☐ | ☐ | |
| | venous | ☐ | ☐ | |
| | arterial | ☐ | ☐ | |
| Liver/Pankreas/Intestine | | ☐ | ☐ | |
| | Hepatitis | ☐ | ☐ | |
| Nerve disease | | ☐ | ☐ | |
| Cancer | | ☐ | ☐ | |
| Leukemia | | ☐ | ☐ | |
| Thyroid disease | | ☐ | ☐ | |
| Bone/Joint disease | | ☐ | ☐ | |
| | Rheumatism | ☐ | ☐ | |
| | Arthritis | ☐ | ☐ | |
| | Back pain | ☐ | ☐ | |
| High cholesterol | | ☐ | ☐ | |
| Fever | | ☐ | ☐ | |
| Weight loss | | ☐ | ☐ | |
| Night sweats | | ☐ | ☐ | |
| Allergies | | ☐ | ☐ | |
| Smoker | | ☐ | ☐ | |
| | | ☐ | ☐ | |
| | | | | |

# Check-up Questionaire

## Medication

| Name/Generic | Dosage (mg) | Frequency (e.g.1-0-1) | Duration |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Hospital admissions and/or Surgery

| Name of Hospital | Reason | Date/Duration |
|---|---|---|
| | | |
| | | |
| | | |

## Further comments