Dr. Ursula Koch-Turner *Lainzer Straße 139/5* *Tel: 804 87 24*
General medicine *Fax: 804 87 25*

Medical history

Date:……

Name:……...

Address: ……....

Phone number: ……..

Social security number/date of birth: __ __ __ __/__ __ __ __ __ __ __ __

E-mail :

Questions about your health

What is the reason for this medical examination?

Have you experienced physical discomfort lately? □ YES □ NO

Were you in hospital over the last year? □ YES □ NO

Do/did you have cancer?
□ YES □ NO

if yes, which one/s?.....

Have you ever had any of the following symptoms during physical exertion:

Unconsciousness? □ YES □ NO

Dizziness? □ YES □ NO

Chest pain? □ YES □ NO

Unusually strong shortness of breath?
□ YES □ NO

Additional heartbeats/palpitations?
□ YES □ NO

Have you ever had a head injury?
□ YES □ NO

Have you ever had an epileptic seizure? □ YES □ NO

Do/did you have any of the following conditions?

High blood pressure
□ YES □ NO

Diabetes □ YES □ NO

Metabolism disorder
□ YES □ NO

Heart (arrhythmia, Angina pectoris, cardiac arrest, heart valves, etc.)
□ YES □ NO

Head/brain (frequent headaches, migraine etc.) □ YES □ NO

Airways, lung (also asthma)
□ YES □ NO

Thyroid □ YES □ NO

Stomach disease □ YES □ NO

Liver disease □ YES □ NO

Joints (rheumatism) □ YES □ NO

Gout □ YES □ NO

Kidney disease □ YES □ NO

Skin disease □ YES □ NO

Mental disorder □ YES □ NO

Please turn the page

Do you have allergies?

□ YES □ NO

If yes, which one/s?

……………………………….

What kind of symptoms?

……………………………..

Do you smoke?

□ NEVER
□ PREVIOUSLY: when did you stop?
□ YES: how many? ,since when?

How many alcoholic drinks do you usually drink in a week? (1 drink: 1/4l beer, 1/8l wine, 20ml schnapps)

……………………………………………
……………………………………………

Do you eat a special diet? (e.g.: vegan, vegetarian, Keto, paleo, etc..,)? □ YES □ NO

Are you happy with your weight?

□ YES □ NO

FOR WOMEN

Do you take the pill?

□ YES □ NO

Could you be pregnant right now?

□ YES □ NO

CHILDHOOD DISEASES:

Which of the following childhood diseases did you have?

□ Measles □ Mumps
□ Rubella □ Scarlet fever
□ Whooping cough □ Chickenpox
□ Diphteria □ I don‘t know

FAMILY HISTORY:

Did/does any of your blood relatives (parents, grandparents, siblings, children) have any of the following diseases?

□ Heart disease □ Stroke
□ Blood pressure □ High cholesterol
□ Diabetes □ Cancer
□ Allergies
□ Sudden cardiac death
□ High blood pressure

Did a blood related family member die before they turned 40?

□ YES □ NO

DATES OF THE LAST VACINES (YEAR)

Tetanus: …… □ I dont know □ not vaccinated
FSME: ………□ I dont know □ not vaccinated
Polio: ……… □ I dont know □ not vaccinated

Do you take regular MEDICATION?

□ YES □ NO

If yes which one/s?

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Are you happy with your performance?

□ YES □ NO, not completely
□ NO, not at all

Do you work out regularly?

□ YES, all year
in total ….. hours per week
□ NO, seldom or never

Vielen Dank!