

Innere Medizin – Gastroenterologie

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QEP 1.2.1				

Questionnaire

Veröffentlichung / Freigabe
Dr. med. Moritz Hanig

Name Mr./Mrs..... Date of Birth:.....

Home phone:.....(daytime phone):Cell phone:.....

Occupation/ Employer:Email-Address:.....

Insurance..... Referring physician / family doctor:.....

Please answer the following questions regarding your state of health as accurate as possible, so that we are able to prevent possible risks. All information given is subject to medical confidentiality and data privacy requirements and will be handled strictly confidential.

Cardiovascular diseases:		Infectious diseases:	
High blood pressure	<input type="checkbox"/> yes <input type="checkbox"/> no	AIDS/HIV	<input type="checkbox"/> yes <input type="checkbox"/> no
Valvular heart disease/surgery/ Cardiac pacemaker	<input type="checkbox"/> yes <input type="checkbox"/> no	Hepatitis	<input type="checkbox"/> yes <input type="checkbox"/> no
Coronary heart disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Tuberkulosis	<input type="checkbox"/> yes <input type="checkbox"/> no
Seizure disorder (Epilepsy)	<input type="checkbox"/> yes <input type="checkbox"/> no	Allergies / Intolerances:	
Asthma/pulmonary disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Local anesthetics/injections	<input type="checkbox"/> yes <input type="checkbox"/> no
(blood) coalgulation disorder	<input type="checkbox"/> yes <input type="checkbox"/> no	Antibiotics	<input type="checkbox"/> yes <input type="checkbox"/> no
Diabetes mellitus	<input type="checkbox"/> yes <input type="checkbox"/> no	Pain relievers	<input type="checkbox"/> yes <input type="checkbox"/> no
Drug dependency	<input type="checkbox"/> yes <input type="checkbox"/> no	Soy	<input type="checkbox"/> yes <input type="checkbox"/> no
Kidney disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Food	<input type="checkbox"/> yes <input type="checkbox"/> no
Liver disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Metals	<input type="checkbox"/> yes <input type="checkbox"/> no
Metabolic disorders	<input type="checkbox"/> yes <input type="checkbox"/> no	Latex	<input type="checkbox"/> yes <input type="checkbox"/> no
Abdominal operation	<input type="checkbox"/> yes <input type="checkbox"/> no	Other:	
Other diseases?	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, which	
Are you currently pregnant?	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, which month of pregnancy are you in?	
Is there a history of cancer in your family?	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, what kind?	
Have you ever had an endoscopy?	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, when/where?.....	

To be continued on backside

List the names of all the drugs your are currently taking: (e.g. Marcumar, Aspirin, Plavix, Iscover, Antibaby-pill..??)			
Have you experienced bad or allergic reactions to surgeries in the past?		If yes, when/what kind/where?	
Have you had a history of cancer?		If yes, when/what kind?	
Body weight in kg:		Height in cm:	
I am suffering from:		Sonstige Beschwerden	
Difficulty swallowing	<input type="checkbox"/> yes <input type="checkbox"/> no	Cardiovascular	<input type="checkbox"/> yes <input type="checkbox"/> no
Abdominal pain	<input type="checkbox"/> yes <input type="checkbox"/> no	Respiratory	<input type="checkbox"/> yes <input type="checkbox"/> no
Flatulation	<input type="checkbox"/> yes <input type="checkbox"/> no	Musculoskeletal system	<input type="checkbox"/> yes <input type="checkbox"/> no
Diarrhea	<input type="checkbox"/> yes <input type="checkbox"/> no	Sleeping disorder	<input type="checkbox"/> yes <input type="checkbox"/> no
Constipation	<input type="checkbox"/> yes <input type="checkbox"/> no	Snoring / apnea	<input type="checkbox"/> yes <input type="checkbox"/> no
Bleeding	<input type="checkbox"/> yes <input type="checkbox"/> no	Faintings	<input type="checkbox"/> yes <input type="checkbox"/> no
Irregularities in bowel movement	<input type="checkbox"/> yes <input type="checkbox"/> no		
Poor appetite	<input type="checkbox"/> yes <input type="checkbox"/> no		
Weight loss / weight gain	<input type="checkbox"/> yes <input type="checkbox"/> no		
Do you smoke?	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, how many cigarettes per day?	
Do you drink alcohol?	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, how many units per day:	
Foreign visits	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes: where, especially stays in the tropics?	
I am uncomplaining.	<input type="checkbox"/> yes <input type="checkbox"/> no		
Other discomforts - Please describe your discomforts in your own words:			
When did the discomforts initially begin?			
What leads to a deterioratoin and what leads to an amelioration of discomforts?			
According to you, what is the cause of your discomforts?			
How or through whom did you learn about our practice (e.g. internet, colleagues, friends, relatives, other doctor?)			

I agree to the electronic storage and processing of my personal data as well as to its submission via fax/letter.

I commit myself to immediately communicate all changes, which arise during the period of treatment. Additionally, I commit myself to keep all appointments fixed or to cancel them not less than 2 days ahead.

Frankfurt, (date) Signature: