ANAMNESTIC QUESTIONNAIRE

ProCare | člen siete Penta Hospitals

FIRST AND LAST NAME:

BIRTH IDENTIFICATION NUMBER:

TELEPHONE CONTACT:

MAIL ADDRESS:

1. PERSONAL MEDICAL HISTORY

Are you being treated for any of the conditions listed below?

Diabetes	☐ yes	☐ no	from which year:
High blood pressure	☐ yes	☐ no	from which year:
High cholesterol	☐ yes	☐ no	from which year:
Heart disease	☐ yes	☐ no	from which year:

Other
(overcome illnesses, follow-up with specialist doctors, operations, accidents, infection diseases - e. g. hepatitis, etc., please also indicate the year/your age when they occurred)

2. FAMILY MEDICAL HISTORY (PARENTS, SIBLINGS, CHILDREN)

Has anyone been treated for one of the following conditions?

Diabetes	☐ yes	☐ no	how many family members:
High blood pressure	☐ yes	☐ no	how many family members:
Cardiovascular diseases	☐ yes	☐ no	how many family members:
Tumor diseases	☐ yes	☐ no	how many family members:
			type:
Blood clotting disorder	☐ yes	☐ no	how many family members:

Other
(overcome illnesses, follow-up with specialist doctors, operations, accidents, infection diseases - e. g. hepatitis, etc., please also indicate the year/your age when they occurred)

3. ALLERGIC MEDICAL HISTORY

(for medicines, food, other substances)

4. WORK MEDICAL HISTORY

(e.g. job classification, smoking in the workplace, working with chemicals, outdoors, in the cold, working at night, overtime...)

5. TAKING MEDICATION

(long-term, as needed, nutritional supplements, other)

6. TRAVEL MEDICAL HISTORY

(please specify especially exotic, tropical countries you have visited + year of stay)

7. GYNAECOLOGICAL MEDICAL HISTORY (FOR WOMEN ONLY)

Menstruation	from which year:		
Cycle	regular	☐ yes	☐ no
Hormonal contraception		☐ yes	☐ no
Number of births			
Number of abortions			
Menopause	from which year:		

8. COMPLETED OPERATIONS

year ( ) type ( )

year ( ) type ( )

year ( ) type ( )

year ( ) type ( )

year ( ) type ( )

9. USE OF HARMFUL SUBSTANCES

coffee — from which year/ number per day ( ) / ( )

cigarette — from which year/ number per day ( ) / ( )

alcohol — from which year/ number per day ( ) / ( )

addictive substances — from which year/ number per day ( ) / ( )

10. COMPLETED VACCINATIONS

(e.g. against hepatitis, pneumococcus, tick-borne encephalitis, Covid-19, tetanus, influenza and others)

11. VITAL FUNCTIONS

Sleep
(falling asleep, waking up at night, urinating at night, feeling rested after waking up...)

Appetite
(how many times a day do you eat, regularity, do you suffer from hunger, sweetened drinks, diet)

Weight ( ) stable ☐ yes ☐ no

Height ( )

Stool regular ☐ yes ☐ no painful ☐ yes ☐ no admixture of blood ☐ yes ☐ no

Urination burning ☐ yes ☐ no cutting ☐ yes ☐ no

Movement/sport

12. HEALTH PROBLEMS

(chronic, acute)

13. THE REASON FOR CHOOSING YOUR EXAMINATION

DATE:

SIGNATURE: