Dear Patient,

Please, complete this form and hand it to the receptionist, it will be passed-on to the doctor.
To prevent complications, detailed and precise statements are necessary.

- Have you had any serious **diseases** or **operations?** (like heart attack, cerebral insult, thrombosis of the veins, pulmonal embolia, high blood pressure, diabetes, epilepsy, osteoporosis, asthma, angina pectoris (quinsy), cancer, joint operations, bone fractures, accidents)? Which and when/since when?

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- Are you suffering or have you suffered from **infectious diseases,** like hepatitis A,B,C, tuberculosis, HIV, persistant excretion of salmonella, MRSA, VRE, ESBL?
  Which and when/since when?

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- What **medication** are you presently taking, long term or temporarily?

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- Do you have **metal parts** in your body (heart pacemaker, bone nails, artificial joints, metal splinters, IUP, tooth implant), which and where?

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- Do you have a heart pacemaker? ❍ no ❍ yes
- Are you suffering from varicose veins? ❍ no ❍ yes
- Are you pregnant? ❍ no ❍ yes
- Do you know of allergies against any medication? ❍ no ❍ yes, which?

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- Have you ever had bad experience with physical therapy? Which?

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Name Date of Birth

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Date Signature