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Dear Guest,

Welcome to the Buchinger Clinic Bad Pyrmont. The following medical questionnaire is designed to enhance the quality of your stay. Please answer these questions before consulting the doctors.

All information given is subject to the medical code of confidentiality.

Thank you,
Dr. Verena Buchinger-Kähler
Chief Physician

MEDICAL QUESTIONNAIRE (MQ1)

We kindly ask you to answer all questions correctly in order to simplify the process of medical admission.

Please mark appropriate answers with a cross (X).

Salutation: Mr. Mrs. Ms. Title:

Name: First Name:

Do you wish the final report to be sent to your physician? yes no

Physician:

Emergency contact:

GOAL DURING THIS STAY/REASON FOR YOUR VISIT

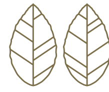
SOCIAL HISTORY

single married since: widowed since:

divorced since:

Occupation:

Children (age):



FAMILY HISTORY

Father: alive deceased of: age:

Mother: alive deceased of: age:

Siblings (number):

alive deceased of: age:

alive deceased of: age:

IMPORTANT FAMILY DISORDERS

Diabetes mellitus | Rheumatism | Heart condition | Overweight

High blood pressure | Mental/psychic illnesses (e. g. Depression)

Carcinosis:

ANAMNESIS

INFECTIOUS DISEASES

HIV/Aids | Tropical disease | Infectious jaundice (hepatitis A, B, C etc.)

Other:

METABOLIC DISORDERS

Diabetes, since: | Tablets since: | Insuline since:

Increased uric acid or gout

Elevated blood lipids, since: | Thyroid disease

Other:

OPERATIONS

Tonsils	Date:	Joints	Date:
Appendix	Date:	Gastrointestinal tract	Date:
Gall bladder	Date:	Thorax	Date:
Uterus/ovaries	Date:	Prostate gland	Date:
Thyroid	Date:	Other	Date:

TRAUMA OR SEVERE ILLNESSES

When?

When?

When?

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EMOTIONAL OR PSYCHOLOGICAL DISORDERS

Did you or are you receiving Treatment?

no	yes – when?

MEDICAL HISTORY (ORGAN SYSTEM RELATED)

CURRENT MEDICAL CONDITIONS

CARDIO VASCULAR SYSTEM

Fainting tendency	Venous disease	Stenocardia (Angina pectoris)	Cardiac arrhythmia
low blood pressure, since		high blood pressure, since	
shortage of breath:	at rest	under strain	
Calf pain (attacks):	at rest	while walking	

RESPIRATORY SYSTEM

frequent infections	Cough	chron. Bronchitis (COPD)	allergic Asthma
shortage of breath	Sinusitis		

DIGESTIVE SYSTEM

Heartburn	Nausea/vomiting	Acid regurgitation	Gastrointestinal ulcer
Painful flatulence	Biliary colic	Jaundice	

Bowel movement:

regular	irregular	constipation	diarrhoea
Blood in the stool			

URINARY TRACT, KIDNEY & GENITALS

Unintentional urination	Urge to urinate		Urinary tract infections
Urination without dicomfort:	often	nights	

Only men:

Change of the urine stream	Erectile dysfunction

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Only women:

Menstruation:

no, menopause since:

Acute pain/condition:

yes, intense average light regular irregular

Duration:

Interval:

Hormonotherapy:

First period (approx.)

Last period (approx.):

Pregnancies:

Number of births:

Last gynaecological examination:

Abnormalities:

Fulfilled desire to have children? yes no

NERVOUS SYSTEM

Headache, since:

Sight disorder, since:

Paralysis, since:

Acroparaesthesia, since:

Epilepsy, since:

Vertigo, since:

Hearing loss, since:

Memory impairment, since:

Stroke, when:

BONES & JOINTS

Abdominal & muscular pain Pain in the vertebral column

Joint pain:

SKIN & HAIR

Allergies, following: tested?

(possibly with detailed information about frequency, type and severity)

Dermatosis, following:

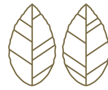
Hair loss:

Itching, where:

VEGETATIVE NERVOUS SYSTEM

Sleep: well poorly

sleep-inducing drugs sleep-onset insomnia sleep-maintenance insomnia chronic fatigue



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Appetite: normal increased decreased intense food cravings, how often:

Aversion or allergies against certain foods:

Thirst: normal increased decreased intake per day in litres:

Night sweat:	no	yes	frequency:
Perspiration/hot flushes:	no	yes	frequency:
Cold/thermal sensitivity:	no	yes	frequency:
Nervousness:	no	yes	frequency:
Attentiveness disorder:	no	yes	frequency:
Tendency to brood/depression:	no	yes	frequency:

MEDICATION

Medication (pharmaceutical ingredient) Dosis & time of intake

RISK FACTORS/LIFE STYLE

Nicotine, average daily: cigarettes

Alcohol, average daily: Litre Beer Wine spirituous beverages

Caffeine, average daily: cups of coffee

Drugs: no yes, following type & duration:

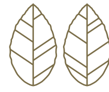
Physical Exercise: little yes, following type & duration:

Stress: no yes, since:

personal interpersonal job-related

Overweight (o.w.):	no	yes
Family members affected by o.w.?	no	yes, who:
Overweight during childhood?	no	yes
Overweight during adolescence?	no	yes, from (–to):

How has your weight developed in the recent past?



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Do you consume regular meals?	yes	no		

Please describe your common daily menu:

Breakfast

Lunch:

Dinner:

Snacks:

Does eating give you pleasure?	average	extensive	major	
How much does your weight affect you?	marginal	moderate	heavily	intensely
Frequent diets?	no	yes		
Former fasting?	no	yes		
Bulimia oder anorexia?	no	yes, when?		

Thank you for taking time to complete this form.

In case you are not able to send this questionnaire beforehand, please bring it to your first examination.