Dok.Typ	Dok.Referenznummer	Rev.-Stand	Ersterstellung / Überarbeitung	Inhaltliche / Fachliche Prüfung
CL	12100000-0005	Rev 08	07.06.2022 C. Landmann	04.08.2022 Dr. med. Moritz Hanig
QEP 1.2.1				

Questionaire

Veröffentlichung / Freigabe: 04.08.2022 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	☐ yes ☐ no	HIV	☐ yes ☐ no
Valvuar heart disease/surgery/ Cardiac pacemaker	☐ yes ☐ no	Hepatitis	☐ yes ☐ no
Coronary heart disease	☐ yes ☐ no	Tuberkulosis	☐ yes ☐ no
Seizure disorder (Epilepsy)	☐ yes ☐ no	**Allergies / Intolerances:**	
Asthma/pulmonary disease	☐ yes ☐ no	Local anesthetics/injections	☐ yes ☐ no
(blood) coalgulation disorder	☐ yes ☐ no	Antibiotics	☐ yes ☐ no
Diabetes mellitus	☐ yes ☐ no	Pain relievers	☐ yes ☐ no
Drug dependency	☐ yes ☐ no	Soy	☐ yes ☐ no
Kidney disease	☐ yes ☐ no	Food	☐ yes ☐ no
Liver disease	☐ yes ☐ no	Metals	☐ yes ☐ no
Metabolic disorders	☐ yes ☐ no	Latex	☐ yes ☐ no
Abdominal operation	☐ yes ☐ no	Other:	
Other diseases?	☐ yes ☐ no	If yes, which	
Are you currently pregnant?	☐ yes ☐ no	If yes, which month of pregnancy are you in?	
Is there a history of cancer in your family?	☐ yes ☐ no	If yes, what kind?	

Internal Medicine and Gastroenterology Clinic

Dres. M. Hanig, S. Blau, M. Seip, A. Borchers, Hochstr. 43, 60313 Frankfurt/M., www.gastroenterologie-ffm.de

Have you ever had an endoscopy?		☐ yes ☐ no	
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:		**Other complains**	
Difficulty swallowing	☐ yes ☐ no	Cardiovascular	☐ yes ☐ no
Abdominal pain	☐ yes ☐ no	Respiratory	☐ yes ☐ no
Flatulation	☐ yes ☐ no	Musculoskeletal system	☐ yes ☐ no
Diarrhea	☐ yes ☐ no	Sleeping disorder	☐ yes ☐ no
Constipation	☐ yes ☐ no	Snoring / apnea	☐ yes ☐ no
Bleeding	☐ yes ☐ no	Faintings	☐ yes ☐ no
Irregularities in bowel movement	☐ yes ☐ no		
Poor appetite	☐ yes ☐ no		
Weight loss / weight gain	☐ yes ☐ no		
Do you smoke?	☐ yes ☐ no	If yes, how many cigarettes per day?	
Do you drink alcohol?	☐ yes ☐ no	If yes, how many units per day:	
Havew discomforts	☐ yes ☐ no	If yes: where, especially stays in the tropics?	
I am uncomplaining.	☐ yes ☐ no		
Other discomforts - Please describe your discomforts in your own words:			
When did the discomforts initially begin?			
What leads to a deteroriaton 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 to the family doctor and/or hospital.

I agree 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: .....