

## Medical history

1. First name, Surname \_\_\_\_\_ date of birth \_\_\_\_\_

e-mail \_\_\_\_\_ tel. \_\_\_\_\_

Address, postcode, place \_\_\_\_\_

2. Describe your present problems:

3. Which other diseases do you have?

4. What kind of operations have you had?

5. What medications do you take currently?

6. Are you aware of any allergies?

medications \_\_\_\_\_ food \_\_\_\_\_

pollen \_\_\_\_\_ others \_\_\_\_\_

7. Do you tend to constipation diarrhea insomnia?

8. current weight \_\_\_\_\_ height \_\_\_\_\_

9. Do you smoke? \_\_\_\_\_

10. How much alcohol do you drink? \_\_\_\_\_

11. Which inoculations have you had? \_\_\_\_\_

12. Are there hereditary, tumor or metabolism diseases in your family?