

MEDICAL QUESTIONNAIRE

Dear patient!

Have you been here before? Please let us know at reception.

Please fill out this questionnaire before your appointment. It will help us to evaluate your allergy symptoms quickly.

Patient Information	Today's Date:
NAME:	
Date of birth: Health insurance number: Health insurance company:	
Phone: E-mail:	
Address:	
Current occupation/profession:	
Place of employment:	

If the patient is co-insured - data of the insured person:
NAME:
Date of birth: Health insurance number: Health insurance company:
Place of employment:

• **Have you been previously tested for allergies?**

- No
- Yes. **Where:** **When:**

The following **allergies** were found:

• **Reasons for visit:**

- | | | |
|--|---------------------------------------|--|
| <input type="radio"/> coughing | <input type="radio"/> itchy eyes | <input type="radio"/> digestive problems |
| <input type="radio"/> difficulty breathing | <input type="radio"/> swollen eyelids | <input type="radio"/> others: |
| <input type="radio"/> running nose | <input type="radio"/> itchy palate | <input type="radio"/> |
| <input type="radio"/> sneezing | <input type="radio"/> itchy skin | <input type="radio"/> |
| <input type="radio"/> stuffy nose | <input type="radio"/> skin rash | <input type="radio"/> |

• **When did the symptoms begin?**

.....

• **Are your symptoms:**

- seasonal*
- all year long

**circle the months where your symptoms are the strongest:*

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

• **When/where are your symptoms worst?**

- | | | |
|--|---|---|
| <input type="radio"/> all day long | <input type="radio"/> in the evening | <input type="radio"/> after meals |
| <input type="radio"/> in the morning | <input type="radio"/> at night | <input type="radio"/> at noon |
| <input type="radio"/> at different times:..... | | |
| <input type="radio"/> at home | <input type="radio"/> at work | <input type="radio"/> after consumption of certain foods: |
| <input type="radio"/> outdoors | <input type="radio"/> during this activity: | |
| | | |

- Did you ever have severe symptoms in connection with:
 - food
 - medications
 - insect stings
 - costume jewellery
 - vaccinations
 - others:

- Do you, or does anyone living with you, smoke?
 - No, I don't.
 - Yes, at most cigarettes a day.
 - Yes, I live in a smoking household.

- Do you have any **pets** or contact with **animals**?
 - No
 - Yes. What kind of animals?

- What symptoms do you have in contact with animals?
 - None
 - Yes:

- Do you have **plants** at your home/work?
 - No
 - Yes:

- Is your home/work place infested with **mould**?
 - No
 - Yes

- What does your **bedding** consist of? (e.g. silk, sheep wool, feathers, ...)

- Do you have any contact with **irritating or toxic substances**?
 - No
 - Yes:

- Does anyone in your family suffer from allergies (parents, siblings, grandparents)?
 - No
 - Yes:

- **Have you been diagnosed with hepatitis/HIV?**
 - No
 - Yes

- **Have you ever had:**
 - Gastritis (medically treated)
 - Ulcers in the gastrointestinal tract (medically treated)

- **Do you suffer from any other diseases?**
 - No
 - Yes:

- Please list **all your medications**, including allergy and non-allergy medications:
 - allergy:
 - non-allergy:

- **Women:** Are you currently pregnant? Yes No
 Do you breastfeed? Yes No

- **During the blood test would you prefer to:**
 - Sit
 - Lie down

PLEASE NOTE: Should you require a medical report sent by postal delivery, please deposit 1.20€ for the stamp; otherwise we will send you the medical report per SMS with a download link.