Name _____ **phone number**_____

Any known allergies and/or drug intolerances ? **no ❑ yes ❑**
please name if yes: _____

_____

Have you ever suffered form any severe illness ? **no ❑ yes ❑**
please name and give dates if yes: _____

_____

_____

Do you suffer from chronic diseases ? **no ❑ yes ❑**
please name and give dates if yes: _____

_____

_____

Did you ever undergo any operation(s) ? **no ❑ yes ❑**
please name and give dates if yes: _____

_____

_____

Are there any severe illnesses in your family history ? **no ❑ yes ❑**
please name if yes: _____

_____

_____

Any regular medication? **no ❑ yes ❑**
please name substances and report dosage if yes: _____

_____

_____

Do you smoke tobacco? no ❑yes ❑ **what / how much?** _____

If no, have you ever been a smoker? **no ❑ yes ❑**

until (year)? _____ **how many years in total?** _____

How much alcohol do you consume?
daily ❑ **1-2 x/week ❑** **rarely ❑** **never ❑**

If yes, please name approx daily/weekly amount: _____

Profession / occupation ? _____

Family yes/no ? _____

The data asked above are used only and exclusively for your medical treatment and are strictly kept under mediacal professional secrecy.