Arbeitsmedizinische Praxis
Dr. medic Diana Bauer

Medical questionnaire

G25 / G41 / FEV / TfV / Sipo / Sakra

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Surname: .....

First name: .....

Date of birth: .....

Employer: .....

Please answer the questions as exactly as possible by marking with a cross.
If you are uncertain about the right answer, leave a blank space. You can clear up by simply asking the company doctor. This questionnaire is very important fort the preparation fort the following conversation between you and your company doctor. Information about your prehistory are therefore required.
Of course all your answer are bound to the medical confidentiality and no information will be transmitted to your employer. Your employer will only be informed if there are general medical doubts in consideration of your job.

I. Self history:	**yes**	**no**
• Do you have health issues at your workplace? - if yes, which of them:	❒	❒
• Did you have an accident with consequential damages? - if yes, which:	❒	❒
• Do you have an intellectual or physical disability? - which:	❒	❒
• Are you aware of any reduction of your ability to work? - which	❒	❒

II. Are you suffering or did you suffer from any of these illness? (mark the right answer or add information)	**yes**	**no**
Eyes (short-sightedness, long-sightedness)	❒	❒
- are you wearing glasses or contact lenses?	❒	❒
Ears (hardness of hearing, tinnitus)	❒	❒
- are you wearing hearing aid?	❒	❒
Thyroid gland (hyperactivity)	❒	❒
Cardiovascular system (heart attac,high blood pressure)	❒	❒
Respiratory tracts (tuberculosis, asthma)	❒	❒
Liver, gallbladder, pancreas (virus hepatitis)	❒	❒
Stomach, intestine (inflamation, ulcer)	❒	❒
Diabetes mellitus	❒	❒
- if yes, are you injecting insulin?	❒	❒
Kidney, bladder (colic)	❒	❒
Spinal column (slipped disc)	❒	❒
Joints (rheumatism, arthrosis, implants)	❒	❒

Surname: _____

	Yes	No
Nervous system (dizziness, migraine, epilepsy, stroke)	❒	❒
Psyche (emotional disturbance, mental illness)	❒	❒
Skin (neurodermitis, psoriasis, eczema)	❒	❒
Hay fever, allergies	❒	❒
- if yes – which?	❒	❒
_____		
• Do you have a breathing disturbance during your sleep? (apnoea)	❒	❒
- do you sometimes stop breathing in your slee for does your partner inform you about this?	❒	❒
- are you sometimes very tired during the day?	❒	❒
- did you ever fall asleep at work for some seconds?	❒	❒
- did you ever fall asleep for some seconds while driving?	❒	❒
• Do you have any chronic illnesses or health disorder? -if yes-which? _____	❒	❒
• Any hospitalization? (operations, accidents) – if yes which and when?	❒	❒
_____		
_____		

III. Current state of your health:	Yes	No
• Do you feel healthy and free of complains?	❒	❒
- if not-which complains do you have?		
• Are you currently in a medical treatment?	❒	❒
- if yes why?		
_____		
• Do you regulary consume medicaments?	❒	❒
- if yes name and dosage?		
_____		
• Are you often under the influence of alcohol?	❒	❒
• Are you somking?	❒	❒
• Do you take drugs?	❒	❒
• Are you pregnant yes/no/maybe	❒	❒

- *I hereby declare that i answered truely and exactly every question on this questionnaire.*
- *I agree with the electronic saving of my data.*
- *Every answer is bound to the medical obligation to preserve secrecy. The transmission of my data requires my written approval.The data is bound to the DSGVO.*

Regensburg, _____ _____
Signature