Dear patient!
In order to provide the best consultation possible, we would like to ask you to fill out **completely** the following questionnaire and hand it back to the reception. All information which you provide here is treated strictly confidential. T**hank you!**

PERSONAL INFORMATION

Last name, first name: ☐ Date of birth: ☐
Telephone: ☐ Occupation: ☐

Marital status: single ☐ married/ committed relationship ☐
Children No ☐ Yes ☐ how many?: ☐

ÄRZTE

Have you ever been to an urologist? **Yes** ☐ **No** ☐
If yes, please provide name and address.

	Name	**Address**
Dr.		

Are you currently treated by a doctor? **Yes** ☐ **No** ☐
If yes, please provide name and address.

	Name	**Address**	**medical speciality**
Dr.			
Dr.			
Dr.			

INFECTIOUS DISEASES

Which infectious diseases are you suffering from at moment <u>or</u> were you suffering from in the past?
Please tick the appropriate box.

Scarlet fever	○ Yes	○ No	○ Don't know	When?	
Rheumatic fever	○ Yes	○ No	○ Don't know	When?	
Mumps	○ Yes	○ No	○ Don't know	When?	
Rubella	○ Yes	○ No	○ Don't know	When?	
Tuberculosis	○ Yes	○ No	○ Don't know	When?	
Hepatitis Type A	○ Yes	○ No	○ Don't know	When?	
Hepatitis Type B	○ Yes	○ No	○ Don't know	When?	
Hepatitis Type C	○ Yes	○ No	○ Don't know	When?	
Sexually transmitted diseases	○ Yes	○ No	○ Don't know	When?	
HIV, AIDS	○ Yes	○ No	○ Don't know	When?	

Other infectious diseases? Yes ☐ No ☐

Allergies

Do you have any allergies that you are aware of? **Yes** ☐ **No** ☐

If yes, please tick the appropriate box!	YES	**Additional information**
dust, grasses, pollen	☐	
Iodine	☐	
Medicines	☐	
X-ray contrast medium	☐	
other	☐	

Other Diseases

Do you suffer from any of the following diseases?
Please tick the appropriate box.

Disease	**YES**	**NO**	**Don't know**	**Treated since when? years / months**
Angina pectoris, coronary artery disease	○	○	○	
Heart attack	○	○	○	
Arrhythmia	○	○	○	
High blood pressure	○	○	○	
lung diseases, e.g. chronic bronchitis, Bronchial asthma	○	○	○	
Circulatory disorders in the legs e.g. intermittent claudication, varicose veins	○	○	○	
Circulatory disorders in the head e.g. stroke	○	○	○	
Diabetes mellitus	○	○	○	
Elevated blood lipids, lipid metabolic disorder	○	○	○	
Gout	○	○	○	
Gastrointestinal problem (e.g. heartburn, ulcers, reflux, etc.)	○	○	○	
Gall bladder diseases	○	○	○	
Malignant diseases, cancer or tumours (e.g. breast, lung, prostate, kidney, uterus, testicles and other organs)	○	○	○	☐ Operation ☐ chemotherapy ☐ radiotherapy
Bladder diseases	○	○	○	
Prostate diseases	○	○	○	
Urinary stones	○	○	○	
Kidney diseases	○	○	○	
Mental diseases, psychosis	○	○	○	
Thyroid diseases	○	○	○	
Other diseases, please specify here	○	○	○	
	○	○	○	

Operations

Did you have any operations? YES ☐ NO ☐

If yes, please tick the appropriate box.	**Yes**	**When?**	**Where? Hospital?**
Inguinal hernia (right ☐ / left ☐)	☐		
Inguinal testicles, undescended testicles (right ☐ / left ☐)	☐		
Appendix	☐		
Gynaecological operations / which?	☐		
Tonsils	☐		
Nasal polyps or nasal septum	☐		
Other operations	☐		
please specify here	☐		

Measurements and Medicines

Do you know your current **weight**? Yes ☐ No ☐ kg

Do you know your **height**? Yes ☐ No ☐ cm

Do you take any **medicines** regularly? Yes ☐ No ☐

If you take medicines, which ones?

Name of the medicine	**Dose**

Habits and Occupational Exposure

How many cigarettes do you smoke per day?

Non-smoker ☐ 1-10 per day ☐ 10-20 per day ☐ >20 per day ☐

For how many years do you smoke or were you smoking? Years

How often do you drink alcohol (e.g. beer, wine, spirits, etc.)?

Never ☐ Rarely ☐ (max. 1x per month) Occasionally ☐ (max. 1x per week) Regularly ☐ (2-3x per week) Often ☐ (daily)

Did you have contact with chemicals like e.g. colourants, dye, solvents and adhesives? YES ☐ NO ☐

Diseases of Immediate Family Members (grandparents, parents, siblings, children)

Which of the following diseases are you aware of in your family?	YES	NO	Don't know	
Renal diseases (e.g. kidney stones, dialysis)	○	○	○	
Tumour diseases	○	○	○	
Diabetes	○	○	○	
Cardiovascular diseases (heart attack, stroke, etc.)	○	○	○	
Thyroid disorders	○	○	○	

Preventative Health Care

Have you ever been to a early detection screening /check-up? Yes ☐ No ☐

If yes, how long ago was it? ______ Years

General Information

How did you find out about us?

☐ business directory / *Which?* ______

☐ Doctolib

☐ Jameda ☐ other internet portals / *Which?* ______

☐ Website of our practice www.aturo.berlin

Recommendation from: ☐ doctor ☐ relatives / friends

☐ other *What?* ______

How long did you have to wait for an appointment?

______ days **Without appointment, acute emergency** ☐

May we remind you of due appointments by SMS or e-mail? Yes ☐ No ☐

May we contact you by e-mail? Yes ☐ No ☐

If yes, please provide your e-mail address here: ______

I agree that information can be given to the following relatives, after their identity has been confirmed at the telephone.

1) Name: ______ 2) Name: ______

Was this questionnaire hard to fill out or difficult to understand?
If yes, what should be changed? ______

Date: ______ **Patient Signature:**______