

Patient questionnaire Dr. Hansen

Name: _____ date of birth: _____

Dear patient,
 please answer the following questions carefully. Any information provided shall remain confidential in accordance with the law governing the medical profession.

your height: _____ cm weight: _____ kg

To what degree do your symptoms affect your quality of life?

0 1 2 3 4 5 6 7 8 9 10

retired? former occupation _____

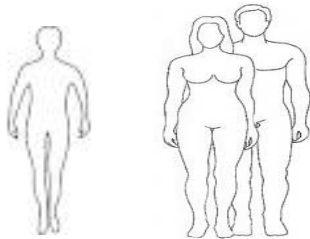
Not at all Slightly Severly Very severely Unbearably

where are your main symptoms?
 (e.g.: right hip)

Do you take any medication for pain relief

Yes No

Which? How often? _____



Are your symptoms the result of an accident?

Yes No

When was the accident? _____

please mark the location of your pain on the drawing

Are you currently unable to work?

Yes, since when _____ No

for how long have you had these main symptoms?

Have you applied for statutory pension?

Yes No

since _____

Are you classed as severely disabled?

If yes, to what degree in %? _____

frequency of the pain (e.g.: pain)

- none at the moment
- infrequent, sporadic (2-4x per year)
- frequency (more than 4x per year)
- only during the day with use
- only at night
- constant, day and night

Have you applied for a disabled person's pass or do you intend to do so?

Yes No

Do you have any additional symptoms which you would like to discuss with me?

1. _____
2. _____
3. _____

Severity of your current symptoms, now, today (please mark with a cross)

0 1 2 3 4 5 6 7 8 9 10
 None Light Medium Strong Very Strong Unbearable

Have you had an x-ray, MRI scan, CT scan or scintigram performed on any part of your skeleton?
 Which part of your body? When?

Do you suffer from allergies? Yes No

If yes, please list below:

1. _____
2. _____
3. _____
4. _____

please turn the page!



Dr. med. Rolf Hansen

Facharzt für Orthopädie und Unfallchirurgie
Chirotherapie, Rheumatologie, Akupunktur
Osteopathie, Sportmedizin, Unfallarzt der BG

Do you suffer from any of the following diseases or disorders?

- Diabetes mellitus (blood sugar disease)
- Highblood pressure
- Rheumatic diseases
- Liver disease
- Kidney disease
- Circulatory problems
- Gastrointestinal disorders, gastric ulcer
- Overactive thyroid
- Other diseases: _____
- Angina pectoris
- Elevated uric acid levels (gout)
- Other heart complaints
- Varicose veins
- Cancer
- Have you got a fever?
- Underactive thyroid
- None**

Do you take Marcumar medication? Yes No

Do you regularly take any medication? Yes No

If yes, please list your medication below:

- 1. _____ 3. _____
- 2. _____ 4. _____

Do you have any medication intolerances? Yes No

If yes, please list your medication below:

- 1. _____ 3. _____
- 2. _____ 4. _____

Which operations have you had?

- 1. _____ 3. _____
- 2. _____ 4. _____

Teeth/jaw

Zähne/Kiefer

Zahnerkrankungen und Zahnwerkstoffe können sich auf die Gesundheit des gesamten Körpers auswirken.

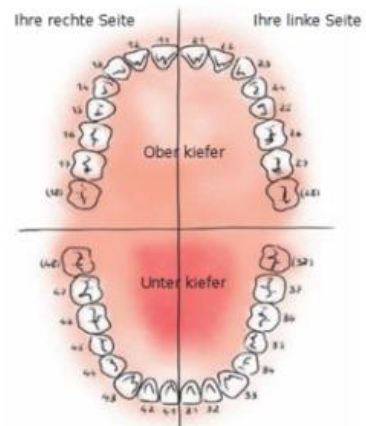
- Erschwerter Durchbruch der Weisheitszähne
- Wurzelbehandelte Zähne
- Tote Zähne
- Empfindliche Zähne auf:
 - heiß kalt
- Parodontose/Parodontitis

Wurden bei Ihnen Amalgamfüllungen entfernt?
Ja Nein

- Zahnfüllmaterialien:
- Amalgam Gold
 - Titan Kunststoff
 - Keramik Palladium
 - Implantate

- Kiefergelenke:
- Schmerzen
 - Geräusche beim Kauen
 - Blockade
 - Zähneknirschen

Bitte markieren Sie behandelte oder erkrankte Zähne oder Zahnfleisch.



Please inform us of any significant changes to the above information!

Date:Signature: