

Questionnaire for health problems – English

Fragebogen Anamnese (für Erwachsene) – Englisch

EN | R1

!!! ACHTUNG: Vertrauliche medizinische Dokumente !!!






Dieser Bogen unterliegt der ärztlichen Schweigepflicht. Eine Meldung von Erkrankungen entsprechend IfSG bzw. AsylG erfolgt bei Bedarf durch die/den erhebende/n Ärztin/Arzt. **Einsichtnahme in diesen Bogen durch oder Übermittlung an nicht-medizinisches Personal (auch Behörden oder Bundesamt) ist nicht gestattet!**

Please fill in the entire questionnaire. The responses are important to help your doctor assessing your state of health and enabling him/her to help you if any problems exist.

Of course, everything you enter in this questionnaire is subject to medical confidentiality: only your doctor will evaluate this questionnaire. Your doctor may only forward this information with your consent! (This is also explained in German in the grey box above.)

If you have any medical documents, please carry them with you to the doctor. Also please have your certificates of vaccination at hand (in case you have any)!

A How is your health in general; would you say it was...

 very good
  good
  fair
  bad
  very bad

B Do you currently have any complaints requiring medical help?

- | | | |
|--|---|--|
| <input type="checkbox"/> 1 fever | <input type="checkbox"/> 6 back pain | <input type="checkbox"/> 11 complaints in genital region |
| <input type="checkbox"/> 2 common cold | <input type="checkbox"/> 7 stomach problems | <input type="checkbox"/> 12 haemorrhoids („piles“) |
| <input type="checkbox"/> 3 vomiting | <input type="checkbox"/> 8 abdominal pain | <input type="checkbox"/> 13 teeth problems |
| <input type="checkbox"/> 4 diarrhoea | <input type="checkbox"/> 9 pain when passing water | <input type="checkbox"/> 14 skin problems |
| <input type="checkbox"/> 5 headache | <input type="checkbox"/> 10 „women's problems/men's problems“ | |
| <input type="checkbox"/> 0 other | | |

C During the last two weeks, how often did you suffer from the following problems?

| | never | rarely | sometimes | often | always |
|--|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| headache | <input type="checkbox"/> A1 | <input type="checkbox"/> A2 | <input type="checkbox"/> A3 | <input type="checkbox"/> A4 | <input type="checkbox"/> A5 |
| abdominal pain | <input type="checkbox"/> B1 | <input type="checkbox"/> B2 | <input type="checkbox"/> B3 | <input type="checkbox"/> B4 | <input type="checkbox"/> B5 |
| other pain | <input type="checkbox"/> C1 | <input type="checkbox"/> C2 | <input type="checkbox"/> C3 | <input type="checkbox"/> C4 | <input type="checkbox"/> C5 |
| fever | <input type="checkbox"/> D1 | <input type="checkbox"/> D2 | <input type="checkbox"/> D3 | <input type="checkbox"/> D4 | <input type="checkbox"/> D5 |
| coughing | <input type="checkbox"/> E1 | <input type="checkbox"/> E2 | <input type="checkbox"/> E3 | <input type="checkbox"/> E4 | <input type="checkbox"/> E5 |
| diarrhoea | <input type="checkbox"/> F1 | <input type="checkbox"/> F2 | <input type="checkbox"/> F3 | <input type="checkbox"/> F4 | <input type="checkbox"/> F5 |
| insomnia/sleep disorder | <input type="checkbox"/> G1 | <input type="checkbox"/> G2 | <input type="checkbox"/> G3 | <input type="checkbox"/> G4 | <input type="checkbox"/> G5 |
| nightmares | <input type="checkbox"/> H1 | <input type="checkbox"/> H2 | <input type="checkbox"/> H3 | <input type="checkbox"/> H4 | <input type="checkbox"/> H5 |
| anxiety/fear | <input type="checkbox"/> I1 | <input type="checkbox"/> I2 | <input type="checkbox"/> I3 | <input type="checkbox"/> I4 | <input type="checkbox"/> I5 |
| feeling of sadness | <input type="checkbox"/> J1 | <input type="checkbox"/> J2 | <input type="checkbox"/> J3 | <input type="checkbox"/> J4 | <input type="checkbox"/> J5 |
| overwhelming memories of bad things I've experienced | <input type="checkbox"/> K1 | <input type="checkbox"/> K2 | <input type="checkbox"/> K3 | <input type="checkbox"/> K4 | <input type="checkbox"/> K5 |
| feeling of not wanting to live any more | <input type="checkbox"/> L1 | <input type="checkbox"/> L2 | <input type="checkbox"/> L3 | <input type="checkbox"/> L4 | <input type="checkbox"/> L5 |

D (for women) Are you pregnant?

☐ 0 no
 ☐ + yes, in the _____th month
 ☐ ? I don't know

Woher erhalte ich diesen Anamnesebogen?

BZgA Bundeszentrale für gesundheitliche Aufklärung Dieser Anamnesebogen wurde von der Bundeszentrale für gesundheitliche Aufklärung (BZgA) entwickelt. Er ist in einer Reihe von verschiedenen Sprachen und in verschiedenen Varianten für unterschiedliche Einsatzzwecke verfügbar. Die jeweils aktuellste Version kann auf der Internetseite der BZgA heruntergeladen werden. Bei diesem Bogen handelt es sich um die Variante R1 English Version 0.8, erstellt am: 19. April 2017