Medical History

Specialist inurology

Name:

Date of birth:

Address:

Phone No:

E-Mail:

Job:

Family doctor:

Do you have any known allergies? ☐ Yes ☐ No

If so, please enter the medicine or substances you are allergic to.

Do you regularly take medication? ☐ Yes ☐ No

If so, please fill in the names of medications or give us your list of medicines.

Are you taking any blood-thinning medication? ☐ Yes ☐ No
(e.g. Marcumar, Aspirin, ASS, Godamed, Plavisor similar)

Have you had any operations? (also not urological) ☐ Yes ☐ No

If so, please fill in the names of medications or give us your list of medicines.

Do you (or have youever had) any of the following diseases?

☐ Diabetesmellitus (sugar disease)

☐ Heart trouble / heart attack

☐ Stomach discomfort (heartburn, stomach ulcers)

☐ Thyroid disease

☐ Hypertension (high blood pressure)

☐ Thrombosis or embolism

☐ Back or intervertebral disc disease

Have you had heaped cancers in your family? ☐ Yes ☐ No

Have you ever had a colonoscopy? ☐ Yes ☐ No

If so, please enter the year:

Do you smoke? ☐ No ☐ Yes, about. cigarettes a day

☐ Not anymore, I have stopped since

For women: Are you pregnant? ☐ Yes ☐ No ☐ Suspect

On which urological topic would you like to be advised and treated?

☐ Preventive / early diagnosis examination of the man

☐ Potency reduction

☐ unfulfilled desire to have children

☐ Incontinence

☐ Urinary tract infection (cystitis)

☐ Kidney disease / stone suffering

☐ Other

How did you find out about our doctor's office / house?

☐ Recommendation by resident doctors (statutory health insurance doctor)

☐ Recommendation / information from friends / relatives

☐ Recommendation / information through the Internet

☐ Recommendation / information through flyer

☐ Recommendation / information from an AOK employee / customer advisor

☐ Other

Date, signature of the patient or legal representative

Patient/in: