

# Examination Questionnaire

Date:  
10/21/2024

Dear Sir or Madam,

The following questions deal with you and your medical history. They help to clarify your state of health and simplify our following conversation. It is therefore in your own interest to answer the questions (front and back) **thoroughly** and **carefully**.

Please write and cross the boxes clearly.

Your answers are bound to professional discretion.

Surname, first name	Pandey, Shivam Rakesh
Date of birth	01/06/2000
Place of birth	Basti, Uttar Pradesh, India
Postal code and residence	53175, Bonn
Street and house no.	Annaberger Str 161
Telephone	+491727474105
Current job position	Doctoral Researcher
Employer	Max Planck Institute for Neurobiology of Behavior - Caesar
Family doctor (Name and address)	

Have you ever had any of the following illnesses ?

	no	yes	Doctor's notes
• Epilepsy, impaired consciousness	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Dizziness, other imbalances	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Stroke, paralysis	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Carcinosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Nervous complaints, psychological illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Eye diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Ear diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Other heart or vascular diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Aneamia, hemic diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Varicose veins, thrombosis, venous leg ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____
• High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Lung diseases / chron. bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Asthma, hay fever, allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Thyroid dysfunctions	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please turn page !

	no	yes	Doctor's notes
• Gastrointestinal illnesses, ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Jaundice, liver diseases, gallstones	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Nephritis or bladder infections/stones	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Spine, joint or muscular ailments	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Rheumatism, rheumatic fever, gout	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Accidents	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Skin diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Breathing dysfunctions related to sleeping	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Other illnesses. If yes, please specify which ones ? (infectious diseases, thyroidal dysfunctions, genital organ illnesses)	<input type="checkbox"/>	<input type="checkbox"/>	_____

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• Have you had any operations ? If yes, when and which ones ? no ☐ yes ☐

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### Further questions regarding yourself:

Do you drink alkohol? Regularly ☐ Occasionally ☐ never ☐

	no	yes
Do you do sport?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke (cigarettes, cigars, pipes)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever smoked?	<input type="checkbox"/>	<input type="checkbox"/>
Do you/have you take(n) medicine regularly?	<input type="checkbox"/>	<input type="checkbox"/>

If yes, what do you/have you take(n)? (incl. pain killers and sleeping tablets)

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Declared severe disability. If yes, to which degree (percentage)? ☐ ☐

Change of work place for health reasons ? ☐ ☐

Driving license restrictions? ☐ ☐

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Signature patient:.....

Passport checked by CAB ☐