




ANAMNESIS QUESTIONNAIRE

 Please fill in the questionnaire. Be so kind and answer all questions completely, regardless of whether you consider them important for your current health problem or not.

1 PATIENT PERSONAL DETAILS

FIRST NAME	LAST NAME
CURRENT HOME ADDRESS	City
NATIONALITY	
MOBILE PHONE	EMAIL ADDRESS

2 PATIENT HEALTH STATUS

<input type="checkbox"/> DIABETES	<input type="checkbox"/> THYROID GLAND	<input type="checkbox"/> HEAPATITIS	<input type="checkbox"/> HIV	<input type="checkbox"/> TUBERCULOSIS
<input type="checkbox"/> BLEEDING DISORDER	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> CIRCULATORY TROUBLE	<input type="checkbox"/> DISEASE OF THE KIDNEY	<input type="checkbox"/> ASTHMA
<input type="checkbox"/> STROKE	<input type="checkbox"/> TUMOR, CANCER	<input type="checkbox"/> EPILEPSY	<input type="checkbox"/> PREGNANCY	<input type="checkbox"/> GASTRO-INTES-TINAL DISEAS
<input type="checkbox"/> DO YOU TAKE ANY MEDICINE REGULARY?	WHICH MEDICINE?			
OTHER DISEASES				

3 PATIENT QUESTIONS & SIGNATURE

DO YOU HAVE ANY QUESTIONS?	
DATE #	PATIENT SIGNATURE

