WILL
MEDICAL
CARE

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 ADRESS

City

NATIONALITY

MOBILE PHONE

EMAIL ADRESS

② PATIENT HEALTH STATUS

- ☐ DIABETES
- ☐ THYROID GLAND
- ☐ HEAPATITIS
- ☐ HIV
- ☐ TUBERCULOSIS
- ☐ BLEEDING DISORDER
- ☐ HEART DISEASE
- ☐ CIRCULATORY TROUBLE
- ☐ DISEASE OF THE KIDNEY
- ☐ ASTHMA
- ☐ STROKE
- ☐ TUMOR, CANCER
- ☐ EPILEPSY
- ☐ PREGNANCY
- ☐ GASTRO-INTES-TINAL DISEAS

☐ DO YOU TAKE ANY MEDICINE REGULARY?

WHICH MEDICINE?

OTHER DISEASES

③ PATIENT QUESTIONS & SIGNATURE

DO YOU HAVE ANY QUESTIONS?

DATE #

PATIENT SIGNATURE