Medical School Hannover **Anamnesis**

Medical Officer

To be filled in by applicant. **Please tick the appropriate boxes ☐**

Surname	First name	Date of birth
Street	Maiden name	☐ male ☐ female
Postal Code, City	Nationality	Children's ages
Private phone number	Place of birth / Country	
Health Insurance	☐ married ☐ single ☐ widowed ☐ divorced	
Family doctor		

Department	Office phone
☐ full-time ☐ part-time hours/week	OE
Shift work planned ☐ Yes ☐ No	
Training as	
Which profession do you carry out?	
Your previous profession?	Where?

Family History Have any of these diseases occurred in your family?

☐ Allergy	☐ Cardiovascular disease	☐ Malignant diseases
☐ Diabetes	☐ Psychic diseases	☐ Asthma
☐ Tuberculosis	☐ Others	

Exposure at the Workplace

Regular work at computer screen? ☐ No ☐ Yes, an average of hours a day

☐ Risk of infection	☐ Genetically modified organisms	☐ Heat ☐ Strong heat ☐ Cold
☐ X-ray radiation ☐ Radio-isotopes	☐ Wetness / dampness	☐ Carrying of heavy loads
☐ Wearing a breathing-apparatus	☐ Dust ☐ Welding	☐ Others
☐ Hazardous materials ☐ Yes, which ones?		☐ Noise

Personal History	**Physician's notes:**
Do you often have headaches? ☐ Yes ☐ No	
Do you wear glasses? ☐ No ☐ reading glasses ☐ distance glasses ☐ contact lenses	
Do you have dizzy turns? ☐ Yes ☐ No	
Do you suffer from ear diseases? ☐ Yes ☐ No	
Do you have bad hearing? ☐ No ☐ Yes, right ear ☐ Yes, left ear	
Do you have a disease of the thyroid? ☐ Yes ☐ No	
Do you have or have had a blood disease? ☐ Yes ☐ No	

Do you suffer from lung diseases?	☐ Yes ☐ No	
Are you prone to bronchial asthma?	☐ Yes ☐ No	
Have you ever had a heart complaint or circulatory problems?	☐ Yes ☐ No	
Are you prone to infections?	☐ Yes ☐ No	
Have you had a heart attack?	☐ Yes ☐ No	
Do you suffer from high blood pressure?	☐ Yes ☐ No	
Do you have diabetes?	☐ Yes ☐ No	
Do you have gastro-intestinal problems?	☐ Yes ☐ No	
Did you have a gastric ulcer or duodenal ulcer?	☐ Yes ☐ No	
Have you had jaundice?	☐ Yes ☐ No	
Do you suffer from liver disease?	☐ Yes ☐ No	
Do you at present feel pain or burning when urinating?	☐ Yes ☐ No	
Do you have varicose veins?	☐ Yes ☐ No	
Do you have back or neck pains?	☐ Yes ☐ No	
Have you ever had a lumbago?	☐ Yes ☐ No	
Do you suffer from articular rheumatism?	☐ Yes ☐ No	
Are you prone to tendon problems in your hands?	☐ Yes ☐ No	
Have you ever had bone fractures?	☐ Yes ☐ No	
Are you prone to skin diseases?	☐ Yes ☐ No	
Do you suffer from allergies? Which ones?	☐ Yes ☐ No	
Do you have a nervous disorder?	☐ Yes ☐ No	
Do you suffer from a psychic disease?	☐ Yes ☐ No	
Are you epileptic? Do you have a convulsive disorder?	☐ Yes ☐ No	
Have you had an accident involving long disablement?	☐ Yes ☐ No	
Have you had surgery? ☐ No ☐ Yes, when? Which?		
Are you under medical treatment at present?	☐ Yes ☐ No	
Are you a smoker?	☐ Yes ☐ No	
Do you drink alcohol? ☐ No ☐ Yes, which? How often?		
Do you take medicine regularly?	☐ Yes ☐ No	
Have you been in rehabilitation?	☐ Yes ☐ No	
Do you have a disabled pass? ☐ No ☐ Yes, % ☐ applied		
Do you sport regularly? ☐ No ☐ Yes, which? How often?		
Do you feel healthy today?	☐ Yes ☐ No	
Your height cm and weight kg.		
Do you have menstruation at present?	☐ Yes ☐ No	
Which children's disease did you have? ☐ Chicken pox ☐ Measles ☐ Mumps ☐ German measles ☐ hooping cough		
Vaccinations: ☐ German measles ☐ Hepatitis A ☐ Tetanus ☐ Tuberculosis ☐ Mumps ☐ Hepatitis B ☐ Diphtheria ☐ Polio ☐ Measles		

I have given these details to the best of my knowledge and belief.

Date **Signature** **Physician**