

ID _____

Health question

Date _____

■ name

surname _____

given name _____

■ adress _____

■ height

cm

■ weight

kg

■ birthday (Year/Mouth/Date)

_____/_____/_____

■ Age

(Male – Female)

■ phone _____

■ occupation _____

■ Nationality _____

· What doctor do you want to see today ?

[Internal Medicine , Dermatology , Allergoimmunology , others]

· What are your syptoms ?

· When did they start ?

· Are there any medications that you take now ? Any medications ,please list.

· Have you had any operations ?

(Yes , No)

· Do you have any allergies to medications or food ? Please list.

· Life Style

Tobacco, cigaret(+ or -) _____

Alcohol(+ or -) _____

Diet(+ or -) _____

Exercise(+ or -) _____

· Would you mind asking you favorite food & sport ?