Title _____
First name _____
Last name _____
House number, street _____
City, postcode _____
Country _____
Email _____
Telephone number _____
Mobile number _____

Medical history questionnaire – cosmetic surgery

Date of birth: _____ year / Height: _____ cm / Weight: _____ kg

1. What is your occupation? _____

2. Have you recently undergone medical treatment?
   ☐ No Yes ☐

3. If yes, for which illness(es)?
   _____
   _____

4. Are you/could you be pregnant?
   ☐ No Yes ☐

5. Do you take any medication regularly?
   ☐ No Yes ☐
   (E.g. painkillers, sleeping tablets, heart or circulation medication, laxatives, anticoagulants containing acetylsalicylic acid – aspirin, ASA – or any other freely-available medication or drugs)
   If yes, which and in what dosage?
   _____
   _____
   _____

6. Have you undergone an operation before during which an anaesthetic was administered?
   (General/local anaesthetic)
   ☐ No Yes ☐
   If yes, which type of operation and when was it performed?
   a) _____ in _____ (year)
   b) _____ in _____ (year)
   c) _____ in _____ (year)

   Did any incidents arise during the anaesthetic?
   ☐ No Yes ☐
   If yes, which? _____

7. Have you received a blood transfusion before?
   ☐ No Yes ☐
   If yes, were there any complications?
   ☐ No Yes ☐

8. Do you currently suffer from one of the following illnesses, or have you in the past?

Diseases of the heart
(E.g. heart attack, angina pectoris, heart defect, shortness of breath when climbing stairs, myositis, cardiac arrythmia)
☐ No Yes ☐

Circulation/vascular diseases
(E.g. stroke, circulatory disorders, varicose veins, high/low blood pressure, thrombosis, embolism)
☐ No Yes ☐

Diseases of the lungs/airways
(E.g. tuberculosis, black lung, pneumonia, asthma, chronic bronchitis, sleep apnea)
☐ No Yes ☐

Diseases of the liver
(E.g. jaundice, hepatitis, adipose degeneration, hardening of the liver)
☐ No Yes ☐

Diseases of the kidneys/urinary passages
(E.g. kidney/renal pelvis infections, kidney/bladder stones)
☐ No Yes ☐

Diseases of the digestive tract
(E.g. heartburn, gastric diseases, chronic intestinal diseases)
☐ No Yes ☐

Nervous disorders
(E.g. epilepsy, paralysis)
☐ No Yes ☐

Metabolic diseases
(E.g. diabetes)
☐ No Yes ☐

Thyroid diseases
(E.g. goitre, hyper/hypofunction)
☐ No Yes ☐

Allergies
(E.g. pollen, grasses, foodstuffs, nickel)
☐ No Yes ☐
Which medication/remedy do you take for this?
_____

Muscle disorders, weaknesses
☐ No Yes ☐

Other diseases not listed above?
(E.g. diseases of the immune system or skin, meningitis, tumours, poisoning)
☐ No Yes ☐
If yes, please provide details _____

Mood disorders
(E.g. depression)
☐ No Yes ☐

Blood disorders or an increased propensity to bleed
(Do you bruise easily, or get nose bleeds for no particular reason?)
☐ No Yes ☐
If yes, which? _____

Diseases of the skeletal system
(E.g. spinal injuries, joint diseases)
☐ No Yes ☐

9. **Other complaints**
(E.g. accidents, serious injuries, special occupational situations)
_____

10. **Lifestyle**
Do you participate in competitive sports?
☐ No Yes ☐

Do you smoke?
☐ No Yes ☐
If yes, what and how many per day?
_____

Do you consume alcohol?
☐ No Yes ☐
If yes, how much on average per day?
_____

Do you take any drugs?
☐ No Yes ☐
If yes, what and often?
_____

11. **Which procedures are you interested in?**
Breast enlargement ☐
Breast reduction ☐
Breast lift ☐
Gynaecomastia ☐
Hair autotransplantation ☐
Liposuction ☐
Tummy tuck ☐
Thigh lift ☐
Facelift ☐
Nose reshaping ☐
Eyelid reshaping ☐
Penis extension ☐
Ear correction ☐
Wrinkle treatment ☐
Other procedure ☐
If yes, which? _____