



Medical history questionnaire

Please answer these questions to the best of your ability. By doing so, you are helping us to find the cause for your health problems as quickly as possible.

General information	
First and last name	
Date and place of birth	
Street	
Country, postcode, town	
Private tel. no.	
Work tel. no.	
Mobile no.	
E-mail address	
Occupation and employer	
Who referred us to you?	

Health-related questions		
Your concern: what brought you to us?		
Do you have an underlying medical disease? Since when, and what was the diagnosis?	<input type="radio"/> yes <input type="radio"/> no	
Acute medical complaints: where and since when?	<input type="radio"/> yes <input type="radio"/> no	
Acute dental complaints: where and since when?	<input type="radio"/> yes <input type="radio"/> no	
Dental treatments in the past 3 years? Which?	<input type="radio"/> yes <input type="radio"/> no	
Have you suffered a mental and/or emotional shock in the past 3 years?	<input type="radio"/> yes <input type="radio"/> no	
For women: are you pregnant, and if yes, how many months?	<input type="radio"/> yes <input type="radio"/> no	_____ month

Nutritional questions		
Do you consume sugar and sugary drinks? If yes, which ones and how often / how much?	<input type="radio"/> yes <input type="radio"/> no	
Do you consume dairy products? If yes, which ones and how often / how much?	<input type="radio"/> yes <input type="radio"/> no	
Do you eat bread and other cereal/grain products?	<input type="radio"/> yes <input type="radio"/> no	
Do you eat meat or sausages? If yes, which ones and how much?	<input type="radio"/> yes <input type="radio"/> no	
Do you eat fish? If yes, which ones and how often / how much?	<input type="radio"/> yes <input type="radio"/> no	

Lifestyle questions		
Do you smoke? If yes, how often / how much?	<input type="radio"/> yes <input type="radio"/> no	
Do you consume alcohol? If yes, which products and how often / how much?	<input type="radio"/> yes <input type="radio"/> no	
How many hours a day do you spend with digital media (TV, computer, smartphone, tablet) on average?		
Do you use a DECT telephone (cordless) at home or at your place of work?	<input type="radio"/> yes <input type="radio"/> no	
Do you make phone calls with your smartphone placed next to your ear? If yes, how many minutes a day?	<input type="radio"/> yes <input type="radio"/> no	
How far is the next cell tower from where you sleep, and since when?		
Do you have Wi-Fi at home and do you turn it off at night?	<input type="radio"/> yes <input type="radio"/> no	
Do you have Wi-Fi reception from surrounding buildings or apartments?	<input type="radio"/> yes <input type="radio"/> no	
Do you have a demand switch in your apartment / in your house?	<input type="radio"/> yes <input type="radio"/> no	
Do you exercise and if yes, which types of exercise and how often / how much?	<input type="radio"/> yes <input type="radio"/> no	
How many hours do you sleep on average each night?		
What percentage of your waking hours would you categorise as being stressful?		

Signature	
I hereby confirm with my signature that all the information provided here is truthful and that I will bear all costs of the treatment, regardless of any reimbursements from payers.	Location, date, signature
I hereby confirm with my signature that I agree with the data collection for scientific purposes and the presence of qualified personnel for education purposes	Location, date, signature