PNEUMOLOGIE SOLLN
Prof. Dr. med. Jan Hendrik Storre

Medical History - Information

Last name:	First name:	Age:
Body weight:	body height:	
What is your profession?		
Who is your family doctor?		
What is your medical problem? When did it start?		
Do you smoke? Cigarettes per day?	Yes ☐ Since how many years?	No ☐
Do you take any medication? Please list your medication in detail?	Yes ☐	No ☐
Other pre-existing diseases?		
Pre-existing lung diseases in your family? If yes, please list?		
Last X-ray photograph/CT-Scan?		

Are you suffering under the following circumstances?

	Yes	No
During special seasons Which seasons in particular?		
During special activity? Which activities are related to medical problems?		
Association to intense smell or smoke?		
Association to defined surroundings/areas? Which one?		

Do you you have any of the following diseases?

	Yes	No	No idea
HIV, Hepatitis?			
Asthma, breathlessness?			
Night sweat, unintentional weight loss			

	Yes	No	No idea
headache			
urticaria			
cinustits			
increase in sputum (yellow?)			
cough			
bronchitis			
ongoing sneezing			
problems regarding nose breathing			
tear droping or pruritis at eyes			
recurrent swelling around the eyes			
pruritis in the throut			
snoring or breathing abnormalities during night?			
are you recovered and fresh at morning after sleep?			
frequent daytime sleepiness?			
are you pregnant? week of pregnancy?			

History of allergies?

	Yes	No
Known allergies (e.g. medication, food, animals, grass, pollen? If yes, please list		
allergie-tests performed prior to this visit? what Year?		
any hyposensitization before? what year and for how long?		
Do you have pets? If yes, please list your pets		

Climate in your flat/house?	☐ dry ☐ humid
Any problems regarding mould fungus?	☐ Yes
Further comments/information:	