

Deutsche Klinik  
für Diagnostik  
Wiesbaden

DKD

Your Patient Number:

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Date: \_\_\_\_\_

## Medical Questions

Before your examination

Name: \_\_\_\_\_

Surname: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

For the faithful preparation of your check-up we would like to ask you to provide us with accurate answers to our medical questions.

Your information and data are naturally subject to medical confidentiality and the regulations of the Federal Data Protection Act (BDSG).

**Č** Main complaint (diseases, symptoms), you wish to clarify:

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**More complaints:** If you want clarification  
please mark with a cross

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• Height:  cm      Weight:  kg

**Ž** You are for a medical check-up examination yes      no  
(According to the program attached)      

Further I would like to check on my other complaints  
these are **not** covered by the main check-up program.      

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**3.1 Benefactor**

Self-pay patient according to §7 our general terms of contract  
(See backside of registration)

**3.2 You are company-patient check**      

I would like to check on my other complaints, which are not  
included in the company check-up program:      

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The costs for additional examination

are paid by me

are paid by company   
(Letter of Guaranty)

• **Medical history**

**4.1 Surgeries:**

Year	Type of operation	Hospital

**4.2 Other relevant diseases:**

Year	Type of disease	Hospital

**4.3 Incapable of work within the last 2 years**

How often?

How many days?

• **Births**

Year	Normal birth	Caesarean	Miscarriage

' **Stimulants**

**Nicotine** (Type, number per day) \_\_\_\_\_

**Alcohol** (Type, number per day) \_\_\_\_\_

**Coffee** (Cups per day) \_\_\_\_\_

**Tea** (Cups per day) \_\_\_\_\_

' **Medical family history (blood relatives)**

Diabetes  who: \_\_\_\_\_

Premature heart attack   **F <55 J.**  **M < 65 J.**

Premature stroke   **F <55 J.**  **M < 65 J.**

High blood pressure  \_\_\_\_\_

Hyperlipidemia  \_\_\_\_\_

Cancer  \_\_\_\_\_

Other \_\_\_\_\_

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“ **Medication** you take on a regularly basis:

Name	Quantity	daily	Name	Quantity	daily

Also: Cortison, Marcumar, birth control pill, pain reliever etc.

“ **Are you allergic** against...

Penicillin  \_\_\_\_\_

Contrast agent  \_\_\_\_\_

Other medication  \_\_\_\_\_

Which: \_\_\_\_\_

• **Other informations** which are important:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please send or bring us in consultation with your physician medical findings and X-rays from previous examinations. Please do not forget your patient number provided by us.

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