PD Dr. med. Daniel Bimmler Praxis für Viszeral-Chirurgie

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Fertigkeitsausweis Sonographie des Abdomens SGUM

## Questionnaire for patients

**Name** _____ **First name** _____ **Date of birth** _____

**Family doctor: name, address**

_____

**I'd like the following doctors to receive copies of the medical reports:**

_____

_____

**Have you ever had surgery?** ◯ Yes ◯ No

| Operation | Clinic | Year | Surgeon |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Do you have other diseases?**

_____

**High blood pressure** ◯ Yes ◯ No

**Diabetes** ◯ Yes ◯ No

**Heart condition** ◯ Yes ◯ No

**Allergies** ◯ Yes ◯ No

**Which?** _____

**Nicotine abuse** ◯ Yes ◯ No

**Blood thinner** ◯ Yes ◯ No

**Which?** _____

**Medication** ◯ Yes ◯ No

**Which?**

_____

**Comments**

_____

**Date** _____ **Signature** _____

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