gastropraxis BÜLACH

Patient

Medical history form gastropraxis

1. Do you take medication? Yes □ / No □
   If so, what kind? _____
2. Do you take blood-thinning medications? Yes □ / No □
3. Do you suffer from high eye pressure (Glaukoma)? Yes □ / No □
4. Do you have any known deseases? (special lung or heart) Yes □ / No □
   If so, which ones? _____
5. Have you ever had a surgery on the gastrointestinal tract? Yes □ / No □
   If so, what was operated on? _____
6. Have you ever had an surgery on the abdomen (gynecological, appendectomie, gall bladder, abdomen hernia, etc.)? Yes □ / No □
   If so, what was operated on? _____
7. Do you have artificial hip joint? If so, which side? _____ Yes □ / No □
8. Are you allergic to soya, peanuts or egg white? Yes □ / No □
9. Have you ever had a gastros- or colonoscopy? Yes □ / No □
10. Has been known stomach or colon cancer in your family? Yes □ / No □
    If so, who is affected? _____
11. Please enter height in _____ centimeters and your weigth in _____ kilogram.
12. Do you smoke? □ Yes, about _____ cigarettes per day. □ Non-smoker
13. How do you get home after the examination? _____

Date: _____ Signature: _____