



Surname:

.....

First name:

.....

Date of birth:

.....

Employer:

.....

Please answer the questions as exactly as possible by marking with a cross.

If you are uncertain about the right answer, leave a blank space. You can clear up by simply asking the company doctor. This questionnaire is very important for the preparation for the following conversation between you and your company doctor. Information about your prehistory are therefore required.

Of course all your answer are bound to the medical confidentiality and no information will be transmitted to your employer. Your employer will only be informed if there are general medical doubts in consideration of your job.

I. Self history:	yes	no
<ul style="list-style-type: none"> Do you have health issues at your workplace? - if yes, which of them: <hr/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> Did you have an accident with consequential damages? - if yes, which: <hr/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> Do you have an intellectual or physical disability? - which: <hr/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> Are you aware of any reduction of your ability to work? - which <hr/>	<input type="checkbox"/>	<input type="checkbox"/>
II. Are you suffering or did you suffer from any of these illness? (mark the right answer or add information)		
Eyes (short-sightedness, long-sightedness) - are you wearing glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Ears (hardness of hearing, tinnitus) - are you wearing hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid gland (hyperactivity)	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular system (heart attac,high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory tracts (tuberculosis, asthma)	<input type="checkbox"/>	<input type="checkbox"/>
Liver, gallbladder, pancreas (virus hepatitis)	<input type="checkbox"/>	<input type="checkbox"/>
Stomach, intestine (inflammation, ulcer)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes mellitus - if yes, are you injecting insulin?	<input type="checkbox"/>	<input type="checkbox"/>
Kidney, bladder (colic)	<input type="checkbox"/>	<input type="checkbox"/>
Spinal column (slipped disc)	<input type="checkbox"/>	<input type="checkbox"/>
Joints (rheumatism, arthrosis, implants)	<input type="checkbox"/>	<input type="checkbox"/>

Surname: _____

	Yes	No
Nervous system (dizziness, migraine, epilepsy, stroke)	<input type="checkbox"/>	<input type="checkbox"/>
Psyche (emotional disturbance, mental illness)	<input type="checkbox"/>	<input type="checkbox"/>
Skin (neurodermitis, psoriasis, eczema)	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever, allergies	<input type="checkbox"/>	<input type="checkbox"/>
- if yes – which?	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>		
• Do you have a breathing disturbance during your sleep? (apnoea)	<input type="checkbox"/>	<input type="checkbox"/>
- do you sometimes stop breathing in your sleep for does your partner inform you about this?	<input type="checkbox"/>	<input type="checkbox"/>
- are you sometimes very tired during the day?	<input type="checkbox"/>	<input type="checkbox"/>
- did you ever fall asleep at work for some seconds?	<input type="checkbox"/>	<input type="checkbox"/>
- did you ever fall asleep for some seconds while driving?	<input type="checkbox"/>	<input type="checkbox"/>
• Do you have any chronic illnesses or health disorder? -if yes-which?	<input type="checkbox"/>	<input type="checkbox"/>
• Any hospitalization? (operations, accidents) – if yes which and when?	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>		
<hr/>		
III. Current state of your health:	Yes	No
• Do you feel healthy and free of complains?	<input type="checkbox"/>	<input type="checkbox"/>
- if not-which complains do you have?		
• Are you currently in a medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
- if yes why?		
<hr/>		
• Do you regularly consume medicaments?	<input type="checkbox"/>	<input type="checkbox"/>
- if yes name and dosage?		
<hr/>		
• Are you often under the influence of alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
• Are you smoking?	<input type="checkbox"/>	<input type="checkbox"/>
• Do you take drugs?	<input type="checkbox"/>	<input type="checkbox"/>
• Are you pregnant yes/no/maybe	<input type="checkbox"/>	<input type="checkbox"/>

- I hereby declare that I answered truly and exactly every question on this questionnaire.
- I agree with the electronic saving of my data.
- Every answer is bound to the medical obligation to preserve secrecy. The transmission of my data requires my written approval. The data is bound to the DSGVO.

Regensburg, _____

Signature