Medical History Questionnaire

SWISS BIOHEALTH CLINIC

Please answer the questions to the best of your ability. This will help us find the causes of your health problems more quickly.

General Information	
Ms. / Mr.	please select ...
First name and last name	
Date of birth	
Street	
City, state, zip code, country	
Personal tel. no.	
Work tel. no.	
E-mail address	
Occupation and employer	
Who referred you to us?	

Health-related questions
What are your three main health complaints?
1.
2.
3.
Was there a specific event that occurred just before the first onset of your current symptoms that may have triggered them (e.g. an illness, grief, sadness, shock, surgery, skin rashes, medications, etc.)?
Do you have any allergies (medications, food)? If so, which?
Do you have any intolerances (drugs, food)? If so, which?

Head / neck

Do you suffer from headaches / migraines? If so, how frequently:	
Eyes Conjunctivitis, cataract, nearsightedness, farsightedness, macular degeneration, etc.	
Ears left, right, binaural—middle ear infection, deafness, pain, noise (tinnitus), etc.	
Nose Nose surgeries, hay fever, etc.	
Throat / tonsils Surgery, frequent tonsillitis as a child / currently, sore throat, bad breath.	

Teeth / mouth (please tick as appropriate)

Bleeding gums?	◯ yes	◯ no		
Teeth grinding?	◯ yes	◯ no		
Are your teeth sensitive to hot / cold?	◯ yes	◯ no		
Do you have any root-treated teeth?	◯ yes	◯ no		
Do you have amalgam fillings?	◯ yes	◯ no		
Have you had amalgam fillings removed?	◯ yes	◯ no	How many?	When?
Has an amalgam detoxification been performed?	◯ yes	◯ no	What was used for detoxification?	
Crowns/partial crowns of metal?	◯ yes	◯ no		

Acute dental complaints?

Which?	
Where and since when?	
Dental treatments in the last 3 years - which?	

Past and chronic diseases and operations (use separat sheet, if necessary)

e.g. diabetes mellitus, diseases of the respiratory or cardiovacsular system, autoimmune diseases	

Cancer Diseases

Do you suffer from cancer? If so, which therapies have you received and when?	

Musculoskeletal System

Back surgery, tension, pain, disc problems, cervival/thoracic/lumbar spine, scoliosis, rheumatism, complaints of knees or hips	

General Information

Smoking ◯ yes ◯ no If yes (number of cigarettes, etc.)

Current pregnancy or breastfeeding? ◯ yes ◯ no

Are you or have you been under medical treatment in the last 6 months, if yes, why? ◯ yes ◯ no

Medication

Are you or have you been under therapy with bisphosphonates / anti-resorptiv drugs? ◯ yes ◯ no

Do you take any medications regularly and / or do you receive infusions / injections on a regular base? If so, which? (e.g. anticoagulants, contraceptive pill, vaccination (including against SARS-CoV-2), statins, allopurinol, antibody therapy / immunosuppressants / osteoporosis medication, ...) (use separate sheet, if necessary)

Preparation	Dosage	Taken Since

Please bring existing laboratory results with you (use separate sheet for chronology of medical history, if necessary)

Other Remarks

Signature

By signing, I confirm that all the information provided here is true.	Date	Signature