U R O | L U X

Docteur Chris Roller
Médecin-spécialiste en Urologie

Medical History Questionnaire

Please do not empty your bladder prior to examination!

Name	Surname	Gender	Date of birth
		☐ f ☐ m	
Address		Postal Code/City	
Telephone		Email	
Profession		CNS Social Security Number	
General practitioner			
Do you do any sport?		**Do you smoke?**	
☐ never ☐ regularly ☐ sometimes		☐ yes ☐ earlier ☐ no	
Weight: kg		**Height**: cm	

Preexisting conditions?	
Infectious diseases:	☐ No ☐ HIV ☐ Hepatitis C
Chronic diseases:	☐ No ☐ Hypertension ☐ Diabetes ☐ Heart disease ☐ Asthma ☐ Renal disease
	☐ Epilepsy ☐ Lipid metabolic disorder
Other diseases:	☐ No ☐ Cancer ☐ Mental disorder ☐ Thyroid disease ☐ Thrombosis
Other:	

please turn page→

Have you ever had surgery? Where? When?

Which medications do you take regularly?

Any known allergies against medications?

For female patients:

Are you pregnant? □ No □ Yes

Do you take contraceptives? □ No □ Yes Which?

I hereby declare that the information given is correct.

_____

Date / Patient's Signature

INFORMATION ON THE PROCESSING OF YOUR PERSONAL DATA

Our practice uses an IT system for your patient file, billing, accounting, as well as for communicating with other health professionals where these are involved in your patient care and with public authorities based on their legal obligations.
All information collected in the context of your patient care will be noted in your patient file.
Further information on the processing of your personal data and your rights is available from the secretary's office. This detailed information is available in several languages.