ELLANN® HEALTH

PATIENT HEALTH CHECKUP

Date:

Last name | First name

Date of birth: | Marital status

Street: | City / town:

Occupation:

Phone: | E-Mail:

Are there or have there been people in your family with a chronic disease? (Please insert the letter codes provided on the right for the respective persons. Multiple answers possible)

Father: | Mother:

Children: | Siblings or their children

Paternal:

Grandfather: | Grandmother:

Uncle: | Aunt:

Maternal:

Grandfather: | Grandmother:

Uncle: | Aunt:

Other blood relatives:

M = Infantile eczema
E = Eczema
N = Urticaria
S = Swellings
H = Hay fever
B = Bronchitis
A = Asthma
D = Intestinal disorders
K = Severe headaches
P = Psoriasis
Z = Diabetes
R = Rheumatism / Osteoarthritis / Arthritis
KR = Varicose veins
CA = Cancer
SA = Stroke
HI = Heart attack

General information:

Please describe your 3 main symptoms at this time:
Symptoms since:

Description:

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Have you had or are you currently experiencing the following symptoms?

	Month / year	Month / year
☐ Infantile eczema, cradle cap	Since:	Until:
☐ Croup as an infant	Since:	Until:
☐ Spastic bronchitis	Since:	Until:
☐ Dry cough or chronic bronchitis	Since:	Until:
☐ Productive cough	Since:	Until:
☐ Hay fever	Since:	Until:
☐ Sneezing fits (more than 5 in a row) with runny nose	Since:	Until:
☐ Severe vomiting as an infant or toddler	Since:	Until:
☐ Maxillary / frontal sinusitis	Since:	Until:
☐ Watering / itchy eyes	Since:	Until:
☐ Urticaria	Since:	Until:
☐ Swelling around the eyes or eyelids	Since:	Until:
☐ Eczema or neurodermatitis	Since:	Until:
☐ Migraines or one-sided headaches	Since:	Until:
☐ Diarrhoea, (frequent) digestive problems	Since:	Until:
☐ Frequent, feverish colds	Since:	Until:
☐ Temporary hearing loss	Since:	Until:
☐ High blood pressure	Since:	Until:
☐ Elevated cholesterol levels	Since:	Until:
☐ Diabetes	Since:	Until:
☐ Osteoarthritis, arthritis, rheumatism	Since:	Until:
☐ Kidney disease	Since:	Until:
☐ Chronic bladder infections	Since:	Until:
☐ Women: Irregular menstruation	Since:	Until:
☐ Sleep disorders, stress, fatigue	Since:	Until:
☐ Liver disease	Since:	Until:
☐ Gastrointestinal disease	Since:	Until:
☐ Dizziness	Since:	Until:
☐ Hot flashes	Since:	Until:
☐ Sleep disorders	Since:	Until:
☐ Heart disease	Since:	Until:
☐ Loss of vitality	Since:	Until:
☐ Circulatory disorders	Since:	Until:
☐ Cerebrovascular diseases	Since:	Until:
☐ Varicose veins	Since:	Until:
☐ Depression	Since:	Until:
☐ Other:		

Have you been diagnosed with allergies or have you noted allergic reactions yourself?

Allergies diagnosed by a doctor ☐

Allergies noted yourself ☐

Are you intolerant to any medications?

☐ No ☐ Yes, the following:

What medications are you currently taking or have you taken in the past?

☐ I am not taking any medications ☐ I am currently taking these medications:

Have you had naturopathy in the past?

☐ No ☐ Yes If yes: What? When? Where?

What other therapy have you had to date?

How do you rate the success of the individual treatment methods that were used?

What vaccinations have you had?

Have you been admitted to hospital or stayed at a health resort because of your illness?

☐ No ☐ Yes If yes: When? Where? With what results?

When have the complaints listed under 1. been especially severe in the past?

- ☐ At what age?
- ☐ In certain months?
- ☐ At what time of day or night?
- ☐ When away from home (holiday, friends)?
- ☐ At what time of the year?
- ☐ During your period?
- ☐ At work? (If yes, during what activity?

Have there been times when you had no complaints?

☐ No ☐ Yes If yes: When or on what occasion? (e.g. on holiday, moving, visiting relatives ...)

During what activities are the complaints more severe?

☐ n/a

Housework, hobby, (What?)

Work, sports (What?)

Do you react to intense odours caused by vapour or dust from?

- ☐ n/a
- ☐ Household dust
- ☐ Flour dust
- ☐ Detergent
- ☐ Disinfectant
- ☐ Paint
- ☐ For or smog
- ☐ Bedding / feathers
- ☐ Start of the heating season

Do you come into contact with animals, and what contact with animals is associated with the symptoms?

Do you have respiratory problems? If yes, when do they occur?

Describe the type: Cramps, pressure on the chest, inability to breathe deeply or "someone is squeezing my chest")

Do you have pain? If yes, when does it occur?

☐ Constantly ☐ At intervals ☐ Under certain circumstances

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Describe the pain (stabbing, throbbing, shooting, dull, pressure pain etc.)

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Have you been abroad in tropical/subtropical regions?

☐ No ☐ Yes ☐ If yes, where and when: _____

If yes, have you noted the following symptoms afterwards?

☐ Diarrhoea
☐ Jaundice
☐ Unclear abdominal pain
☐ Unclear skin problems (spots/knots/reddening/ulcers)
☐ Joint pain
☐ Muscle complaints
☐ Impaired vision
☐ Nerve pain / feelings of numbness
☐ Paralysis
☐ Unclear irregular fever
☐ Periodic fever (3 days / 4 days fever)
☐ Exhaustion/fatigue/impaired capacity)

Have you have contact with biting flies, exotic animals such as arachnids, scorpions, parrots?

☐ No ☐ Yes ☐ If yes, where and when: _____

Do you keep tropical animals such as:

☐ Snakes ☐ Reptiles ☐ Spiders ☐ quatic snails / fish Please specify: _____

Do you keep tropical plants?

☐ No ☐ Yes ☐ If yes, please specify: _____

Have you observed unusual weight loss combined with unexplained exhaustion in the last 3 months?

☐ No ☐ Yes

Have you observed noticeable itching on the anus or genitals early in the morning or in the evening?

☐ No ☐ Yes

If you believe that your complaints are associated with your work, please list the working materials you think are causing the complaints.

_____

Do you smoke?

☐ No ☐ Yes ☐ Sometimes ☐ Formerly Number of cigarettes per day? _____

Do you frequently spend time in rooms with heavy smoking?

☐ No ☐ Yes

What dental fillings do you currently have?

☐ Amalgam ☐ Ceramik
☐ Gold
☐ Synthetic

Welche Zahnfüllungen hatten Sie früher?

☐ Amalgam ☐ Ceramik
☐ Gold
☐ Synthetic

Do you have dental bridges?

☐ No ☐ Yes - number _____

Do you have crowns?

☐ No ☐ Yes - number _____

If you have fillings containing metal, crowns and / or bridges, have you observed reddening, swelling and / or discolouration of the gums and mucous membranes in the mouth?

☐ No ☐ Yes

Do you live:

On a street with heavy traffic?

☐ No ☐ Yes Since when? _____ At what distance in m/km: _____

Near a petrol station?

☐ No ☐ Yes Since when? _____ At what distance in m/km: _____

Near agricultural fields?

☐ No ☐ Yes Since when? _____ At what distance in m/km: _____

Near an allotment garden?

☐ No ☐ Yes Since when? _____ At what distance in m/km: _____

Near an industrial facility (chemical/petrochemical industry)?

☐ No ☐ Yes Since when? _____ At what distance in m/km: _____

Near a waste incineration plant or landfill?

☐ No ☐ Yes Since when? _____ At what distance in m/km: _____

Near a nuclear/coal-fired power plant?

☐ No ☐ Yes Since when? _____ At what distance in m/km: _____

Near a horticulture operation with greenhouses?

☐ No ☐ Yes Since when? _____ At what distance in m/km: _____

Near a wind park?

☐ No ☐ Yes Since when? _____ At what distance in m/km: _____

Near an overland power transmission line?

☐ No ☐ Yes Since when? _____ At what distance in m/km: _____

Near a railway station or rail line / express line?

☐ No ☐ Yes Since when? _____ At what distance in m/km: _____

Are there trees and / or shrubs in your neighbourhood that are sprayed regularly (orchards, landscaped gardens, city parks)?

☐ No ☐ Yes Since when? _____ At what distance in m/km: _____

Are you a frequent flier?

☐ No ☐ Yes Long-distance flights per year: _____

Have you noticed the following symptoms after a flight?

☐ Nausea, vomiting
☐ Jaundice
☐ Temporary or permanent feelings of numbness
☐ Impaired consciousness, awareness
☐ Neurological deficits
☐ Headaches

Have you taken cruises?
☐ No ☐ Yes, the following: _____

Have you noted any food intolerances?
☐ No ☐ Yes, the following: _____

Do your complaints often occur around meals?
☐ No ☐ Yes, usually after. . . _____

Do you have flatulence, a bloated upper abdomen, feeling of fullness?
☐ No ☐ Yes, usually after. . . _____

Have you had conspicuous liver values?
☐ No ☐ Yes, _____

Do you have lymph node problems or lymphostasis?
☐ No ☐ Yes, _____

In your opinion, what is your main intolerance, weakness or problem?
Self-diagnosis:

Important patient notes
The following is also important:

Privacy:
I expressly consent to the use of my data and confirm this with my signature.

I agree that the information provided here and the collected personal data may be recorded and processed for diagnosis and therapy purposes. The data may be used exclusively for this purpose and for general medical care. The data may also be recorded in IT systems. This must be done in accordance with the applicable data protection laws. I expressly consent to have my documents sent by E-Mail

I have been informed that I may object to and revoke the consent to use at any time. To do so, I may contact **kontakt@eller-kellermann.de**

Place / date: _____ Signature of patient: _____

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