Twój Doktor
Gabinety Medyczne

PATIENT HEALTH STATUS QUESTIONNAIRE

Patient's full name: ……..

PESEL number: ……. **Date of birth***: ……..…….

ID document type and number (if applicable): ……

Do you generally feel healthy?

YES ☐ NO ☐

Are you currently undergoing any treatment?

YES ☐ NO ☐

If yes, please specify:

…….

Are you currently taking any medications?

YES ☐ NO ☐

If yes, which ones:

…….

Are you allergic to anything?

YES ☐ NO ☐

If yes, please specify:

…….

Do you smoke tobacco?

YES ☐ NO ☐

If yes, how much and since when:

…….

Questions regarding aesthetic medicine procedures:

Have you taken tetracyclines, isotretinoin (Accutane, Izotek)?

YES ☐ NO ☐

If yes, date of last dose:

……..

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Are you taking anticoagulants or aspirin?

YES ☐ NO ☐ If yes, which: ……

Are you taking any herbs, medications or dietary supplements?

YES ☐ NO ☐ If yes, which: ……

Has there ever been inflammation, viral or bacterial infection in the skin area to be treated?

YES ☐ NO ☐

Do you have a tendency to improper wound healing or scar formation?

YES ☐ NO ☐

Do you tan frequently?

YES ☐ NO ☐

Date of last sun or tanning bed exposure:

……

Do you use self-tanning products?

YES ☐ NO ☐

Do you use sunscreen?

YES ☐ NO ☐

Have you used retinol creams in the past 4 weeks?

YES ☐ NO ☐

Have you undergone any skin treatments in the area to be treated in the last 7 days?

YES ☐ NO ☐ If yes, which: ……

Have you ever had or do you currently suffer from any of the following conditions:

Heart disease (myocardial infarction, coronary disease, valve defects, arrhythmia, myocarditis)

YES ☐ NO ☐

Other cardiovascular conditions (hypertension, hypotension, fainting, shortness of breath, fatigue)

YES ☐ NO ☐

Vascular diseases (varicose veins, phlebitis, poor limb circulation, leg pain, nosebleeds, bruising, swelling, slow wound healing)

YES ☐ NO ☐

Blood disorders (if yes, which):

YES ☐ NO ☐ ……

Lung diseases (emphysema, pneumonia, respiratory failure, tuberculosis, asthma, chronic bronchitis)

YES ☐ NO ☐

Digestive tract diseases (ulcers, intestinal conditions, food intolerance)

YES ☐ NO ☐

Liver diseases (gallstones, hepatitis, cirrhosis)

YES ☐ NO ☐

Urinary tract diseases (kidney infections, stones, urination issues)

YES ☐ NO ☐

Metabolic disorders (diabetes, gout)

YES ☐ NO ☐

Thyroid disorders (hyperthyroidism, hypothyroidism, goiter, enlargement)

YES ☐ NO ☐

Neurological disorders (epilepsy, paresis, fainting, paralysis, sensory issues, myasthenia)

YES ☐ NO ☐

Musculoskeletal conditions (back pain, spine/joint degeneration, post-fracture conditions)

YES ☐ NO ☐

Blood and clotting disorders (hemophilia, anemia, bleeding, nosebleeds, prolonged bleeding)

YES ☐ NO ☐

Eye diseases (e.g. glaucoma)

YES ☐ NO ☐

Allergies (e.g. asthma, drug reactions)

YES ☐ NO ☐

Mood disorders (e.g. depression, neurosis)

YES ☐ NO ☐

Infectious diseases (e.g. hepatitis A/B/C, tuberculosis)

YES ☐ NO ☐

Rheumatic disease

YES ☐ NO ☐

Osteoporosis

YES ☐ NO ☐

Frequent infections – how often?

YES ☐ NO ☐ ……

Blood transfusions – how often?

YES ☐ NO ☐ ……

Chemotherapy or radiotherapy – completed or ongoing?

YES ☐ NO ☐ ……

Other complaints or diseases (e.g. swallowing difficulties, lymph node swelling)

YES ☐ NO ☐ If yes, which: ……

Signature of person collecting information

……

Date and legible signature of the patient

……