Interview		
Otto von Guericke Universität Magdeburg Medizinische Fakultät Universitätsklinikum Magdeburg A.ö.R.		
Last name:		
First name:		
Date of birth		Place of birth:
Home adress:		
Private telephone number:	Official telephone number	
Number of children:	Medical insurance:	General practitioner:
Profession:		
Type of work:		
Department:		
Beginning of work:		Ending of work:
Severe disability: yes/no		
Specific exposures at the workplace (please mark with a cross)		
Computer-work:		□ yes □ no
Exposure to toxic substance:		□ yes □ no
Increased risk of infections:		□ yes □ no
Occupationally exposed to radiation:		□ yes □ no
Shift work:		□ yes □ no
Diseases in your family (parents, grandparents, sister, brother)		
Diabetes:		□ yes □ no
Allergies:		□ yes □ no
Cardiovascular disease:		□ yes □ no
Tuberculosis:		□ yes □ no
Other diseases:		□ yes □ no
Have you ever had any of the following diseases ?		
Infectious diseases: (please mark with a cross)	□ chicken pox □ mumps □ hepatitis	□ measles □ rubella/ german measles □ tuberculosis
Other infectious diseases: (please write down)	----------	
Diseases of respiratory system: (please write down)	----------	
Surgery: (please write down – which, when)	----------	
Accidents: (please write down – which, when)	----------	

Have you ever had any of the following diseases ?		
	Please mark with a cross	**If „yes“, please write down** **Which?** **Year?**
Cardiovascular diseases	□ yes □ no	
Gastro-intestinal diseases	□ yes □ no	
Urogenital diseases	□ yes □ no	
Liver and/or gall-bladder diseases	□ yes □ no	
Diabetes	□ yes □ no	
Bone and /or joint diseases	□ yes □ no	
Blood diseases	□ yes □ no	
Metabolic diseases (for example thyroid diseases)	□ yes □ no	
Skin diseases	□ yes □ no	
Allergies	□ yes □ no	
Ophthalmlogical disorder	□ yes □ no	
Ear disorder	□ yes □ no	
Seizures/Convulsions	□ yes □ no	
Nervous systeme diseases or mental health problems	□ yes □ no	
Gynecologic diseases	□ yes □ no	
Pregnancy	□ yes □ no	
Do you take medication on a regular basis?	□ yes □ no	
Do you smoke?	□ yes □ no	**How many?** **For how many years?**
Do you drink alcohol?	□ yes □ no	**How many?** **For how many years?**
Occupational disability	□ yes □ no	

I assure, that I haven’t concealed any diseases, such as epilepsy or other diseases.

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Date Signature