Full name of the examined person: .....

MEDICAL HISTORY

Complaints of the examined person(s):.....

	Yes	No.	Description
Skull injuries			
Injuries to the locomotor system			
Fainting			
Epilepsy			
Other diseases of the nervous system			
Mental illnesses			
Diabetes			
Hearing organ diseases/voice organ diseases			
Eye diseases			
Hematopoietic diseases			
Cardiovascular diseases			
Respiratory diseases			
Gastrointestinal diseases			
Diseases of the genitourinary system			
Diseases of the musculoskeletal system			
Skin diseases / allergies			
Infectious diseases parasitic infections			
Gynaecological and obstetric history (menstruation, pregnancy, hormonal drugs)			
Family interview*			
Other health problems			
Smoking			In the past: Nowadays:
Other stimulants			

Full name of the examined person:

Subjective health assessment	Very good		Good		Rather good		Rather weak		Weak	

	Yes	No	Description – comments
Did the examined person undergo surgery? What kind of surgery? When?			
Is the examined person under the care of a specialist outpatient clinic? Which one?			
Does the examined person take medication? What kind of medicines?			

I declare that I have understood the content of asked questions and have answered them truthfully.

(signature of the examined person)

(signature and stamp of the person drawing the medical history)

Data wydania 15.02.2019 …….