Patient questionnaire
Dr. Peter Bock, Facharzt für Orthopädie

Please fill in this questionnaire if you consult me the first time. You will help me to gather important information (allergies, medication,..) which is relevant for your treatment.

Patient:

Name:	
Forename:	
Date of birth:	
Title:	
Insurance:	□GKK □SVA □BVA □KFA □other:
Private insurance:	□yes □no

Your adress and phone number:

Street:	
Code / Town:	
Phone number:	
Email:	

Other important questions ?

Do you have allergies ? If yes, which allergies ?	□ no □ yes
Are you diabetic ?	□ no □ yes
Do you take coagulation modifying medication ? If yes, which ?	□ no □ yes
Have you already had any orthopedic or traumatologic surgery ? If yes, which and when ?	□ no □ yes
Do you take any dietary supplements ? If yes, which ?	□ no □ yes
Do you take any other medication ? If yes, which ?	□ no □ yes