

What worsens the symptoms? e.g.

- Certain posture
- Walking
- Coughing
- Stress / anger / anxiety
- Lying down / rest
- Sitting
- Standing
- Weather changes
- I cannot influence the pain
- Other factors:

What leads to relief? e.g.

- Distraction
- Change of posture / position
- Relaxation
- Cold
- Heat
- Light movement
- Lying down / rest
- Positive thinking
- I cannot influence the pain
- Other factors:

Are there accompanying symptoms? (e.g.)

- Radiating pain
- Numbness / abnormal sensations
- Weakness / reduced strength / stumbling
- Dizziness

- Swelling / joint effusion tendency
- Feeling of instability
- Other:

Previous surgeries?

Serious illnesses (past or present)?

- | | | | |
|----------------------------------------------|--------------------------------------------|---------------------------------------|-----------------------------------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thrombosis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Herniated disc |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Viral disease |
| <input type="checkbox"/> Asthma / COPD | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Fibromyalgia |

Other pre-existing conditions:

Current medications:

Dosage

Do you take blood thinners such as Aspirin, Marcumar, Plavix, Iscover, Xarelto? Others?

- none

Do you take dietary supplements or homeopathic preparations (e.g., globules)?

Do you have any food intolerances ?

Have you ever had allergies or intolerances to grasses, pollen, medications, injections, pain injections, or metals? If yes, to what? Please bring your allergy passport if available.

→ **Continue to page 3 of 3**

Past accidents?

Do you have metal implants in your body?

(e.g., artificial joints, stent, plates, screws, pacemaker, others?)

Do you use orthopedic aids? (e.g., insoles, shoe lift, braces, cane, walker)

Please tick the appropriate box:

- | | |
|--------------------------------------------------------------------------|----------------------------------------------------------------------------|
| <input type="checkbox"/> Unfit for work since/...../..... | <input type="checkbox"/> Loss of strength and tendency to fall |
| <input type="checkbox"/> Fever – night sweats – infection | <input type="checkbox"/> Frequent bone fractures |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Rest pain and night pain |
| <input type="checkbox"/> Eye inflammation | <input type="checkbox"/> Psychological problems |
| <input type="checkbox"/> Skin disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Frequent joint swelling and prolonged stiffness | <input type="checkbox"/> Teeth grinding – temporomandibular joint problems |
| <input type="checkbox"/> Bladder infection | <input type="checkbox"/> Pelvic tilt – leg length discrepancy |
| <input type="checkbox"/> Tick bite | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Loss of height |
| <input type="checkbox"/> Cigarette consumption / smoking _____ per day | |

Please send us the completed medical history form in advance so that we can prepare for your visit. We kindly ask you to silence your cell phone during your visit to the practice. Taking photos in the doctor's office is not permitted for data protection reasons.

Preparing for a doctor's appointment

**If this is your first visit,
please arrive 15 minutes
Before your appointment**



Data Protection Notice



Thank you very much, Your Practice Team



Privatpraxis für Ihre
Rückengesundheit

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