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Dr. med. Dent. Sandra Umbreit
Dr. med. Anke Buschmann
Ximena Martinez

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Case history

Please fill out this questionnaire carefully and bring it to your first appointment.

Please put a cross by the examples if they apply, or answer in your own words.

Note: You can fill this PDF file directly on PC / Tablet / Smartphone.
However, editing in browsers (e.g. Microsoft Edge) may be faulty, so please use common PDF viewers such as Adobe Reader or the PDF X Change Viewer.
You are also welcome to print out the medical history form and fill it out by hand.

Please take enough time to complete it carefully.

Title | First name | Surname

Street | House/flat number

Postcode | Town/city | Country

Date of birth | Place of birth | Time of birth

Height/body weight | Occupation

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Fixed line	Mobile phone	Mail

1 Complaints

What symptoms are you currently suffering from?

Please indicate the duration and intensity of the symptoms on a scale from 0 to 10.

Please write down the symptoms in order of severity.

	since:	Intensity (1-10):
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

What therapy have you already received for these symptoms?

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How many doctors/clinics/complementary therapists have you been to so far?

How successful was the therapy?

☐ very good ☐ Good ☐ Moderate ☐ Poor ☐ Very Poor

What was your condition directly before your current symptom/s emerged?

☐ A cold ☐ Sorrow ☐ Grief ☐ Fright ☐ Operation/s ☐ Skin condition/eruptions ☐ Other:

What medications/supplements are you currently taking?

Name:	Since:	Daily dose:
Name:	Since:	Daily dose:
Name:	Since:	Daily dose:
Name:	Since:	Daily dose:
Name:	Since:	Daily dose:
Name:	Since:	Daily dose:
Name:	Since:	Daily dose:
Name:	Since:	Daily dose:

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Do you suffer from allergies: ○ Yes ○ No

If yes: to what? (Food related intolerances/allergies please in section 5)

What do you expect from our therapy?

2 Medical history

Chronology:

Please list all the illnesses and operations that you have undergone.

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Which infectious diseases have you had?

☐ Measles	☐ Chickenpox	☐ Malaria	☐ Mononucleosis
☐ Mumps	☐ Scarlet fever	☐ Salmonella	☐ Gonorrhoea
☐ Rubella	☐ Tetanus	☐ Dysentery	☐ Tropical diseases
☐ Hooping cough	☐ Polio	☐ Syphilis	☐ Tuberculosis

Were these diseases (or others) treated with antibiotics? ○ Yes ○ No

If so, which were used?

Do you have scars from operations? ○ Yes ○ No

Do you often get colds? ○ Yes ○ No

What illnesses have members of your family suffered from?

☐ Cancer	☐ Multiple sclerosis	☐ Epilepsy	☐ Gout
☐ Psychiatric diseases	☐ Allergies	☐ Heart diseases	☐ Dandruff
☐ Vascular diseases	☐ Neurodermatitis	☐ Stroke	
☐ Asthma	☐ Tuberculosis	☐ Diabetes mellitus	
☐ Rheumatism	☐ Venereal diseases	☐ Stones	☐ Other:

3 Vaccinations

Did you received vaccinations ? If so, which ones? ○ Yes ○ No

☐ Cholera	☐ Hepatitis	☐ Mumps	☐ Sars-Cov-2
☐ Chickenpox	☐ Hooping cough	☐ Pneumococci	(Corona/Covid19)
☐ Diphtheria	☐ HPV	☐ Polio	☐ Tetanus
☐ Flu	(Human papilloma virus)	☐ Rotavirus	☐ Tuberculosis (BCG)
☐ HiB	☐ Measles	☐ Rubella	☐ Yellow fever
(Haemophilus influenzae b)	☐ Meningococci C	☐ Smallpox	☐ Other:

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Did you had reactions to vaccinations?

☐ High temperature ☐ Cramps ☐ Anxiety ☐ Insomnia ☐ Behavioural changes

4 Emotional symptoms

Do you react to warmth in summer? ○ Yes ○ No

Are you sensitive to touch? ○ Yes ○ No

Are you affected by a closed collar? ○ Yes ○ No

Are you affected by a tight belt? ○ Yes ○ No

Do you like constricted spaces (lifts, etc.)? ○ Yes ○ No

Do you lack concentration? ○ Yes ○ No

Are you tired and exhausted? ○ Yes ○ No

Do you suffer from heightened irritability? ○ Yes ○ No

Fear/guilt feelings/conflicts? ○ Yes ○ No

Do you do sport regularly? ○ Yes ○ No

Do you sweat easily? ○ Yes ○ No

Do you sweat at night? ○ Yes ○ No

At which part of your body?:

☐ **Cold sweats** ☐ **Warm sweats**

Do you get cold easily? ○ Yes ○ No

Do you get cold hands or feet easily? ○ Yes ○ No

How resilient and productive do you feel?

○ Very resilient ○ Moderately resilient ○ Not at all resilient

How is/was your relationship with your parents?

○ Very good ○ Good ○ Moderate ○ Poor

Do you have a partner? ○ Yes ○ No

If so, how is your relationship with your partner?

○ Very good ○ Good ○ Moderate ○ Poor

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Are you happy? ○ Yes ○ No

5 Nutrition

How many litres do you drink a day? _____ **litres**

What do you drink mostly?

What foods do you eat?

☐ Dairy products ☐ Sweets ☐ Products made from white flour ☐ Cakes ☐ Eggs ☐ Sugar ☐ Nuts

What foods do you find it hard to do without?

Craving for foods that are:

☐ Sweet ☐ Sour ☐ Savory ☐ Bitter ☐ Salty ☐ Spicy ☐ Meat ☐ Eggs ☐ Fruit ☐ Nicotine ☐ Alcohol

Aversion to food that are:

☐ Sweet ☐ Sour ☐ Savory ☐ Bitter ☐ Salty ☐ Spicy ☐ Meat ☐ Eggs ☐ Fruit ☐ Nicotine ☐ Alcohol

Food allergies/intolerances to:

Do you live according to certain food guidelines? If so, which?: ○ Yes ○ No

Were you breastfed? ○ Yes ○ No

Did you have a natural birth? ○ Yes ○ No

Are you willing to improve your nutritional habits with our assistance? ○ Yes ○ No

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6 House/flat

Has where you sleep and work been investigated for geopathic stress and electromagnetic poilution? ○ Yes ○ No

Any interference near/in your house/flat?

- ☐ Telegraph poles nearby
- ☐ Overhead cables/railway electricity nearby
- ☐ Streams/rivers nearby
- ☐ Mould
- ☐ Damp spots or known water damage
- ☐ Antiques/wood protection agents
- ☐ Carpets
- ☐ Microwave

Describe the area where you sleep:

- ☐ Cordless phones/Internet
- ☐ Electrical devices in standby mode
- ☐ Waterbed
- ☐ Installed electric motor

What is your sleep like?

- ☐ Insomnia
- ☐ Wake up frequently at: _____ o'clock
- ☐ Urinate at night. How often?: _____
- ☐ Difficulty falling asleep
- ☐ Restless legs
- ☐ Talk in my sleep
- ☐ Night sweats
- ☐ Hot feet
- ☐ Tooth grinding
- ☐ Lively dreams

Position when asleep

☐ Stomach ☐ Back ☐ Left ☐ Right ☐ Sitting ☐ Kneeling ☐ Rolled up

7 Head • Neck

Do you suffer from headaches? If so, how?: ○ Yes ○ No

- ☐ Often
- ☐ Seldom
- ☐ Forehead/eyes/temples
- ☐ Back of the head
- ☐ Evenings
- ☐ Mornings
- ☐ On one side of the head:
- ☐ Left
- ☐ Right
- ☐ Wandering from left to right
- ☐ Wandering from right to left
- ☐ Both sides

Trigger of the headaches, if known:

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What improves it?

What makes it worse?

Hair

Do you suffer from hair loss? If so: ○ Yes ○ No

☐ Circular ☐ Scattered Since: ○ Weeks ○ Month ○ Years

Eyes

☐ Frequent conjunctivitis ☐ Short-sighted ☐ Far-sighted ☐ Glaucoma ☐ Cataract

☐ Other complaints:

☐ Glasses since (year): ☐ Dioptries:

Ears

☐ Pain, left
☐ Pain, right
☐ Both sides
☐ Frequent otitis media
☐ Hard of hearing
☐ Noises in the ears
☐ Ear pressure

Teeth / jaw

☐ Freament visits to the dentist
☐ Teething complaints
☐ Difficully with wisdom teeth coming through
☐ Root treatment
☐ Dead teeth
☐ Teeth sensitive to:
☐ Heat ☐ Cold ☐ Sweet ☐ Sour

Do you have dental finllings? If so, of which material? ○ Yes ○ No

☐ Amalgam ☐ Gold ☐ Titanium ☐ Plastic ☐ Ceramic ☐ Palladium

☐ Other:

Have amalgam fillings been removed? ○ Yes ○ No

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Nose

☐ Operations
☐ Hay fever
☐ Restricted nasal breathing
☐ Blocked nose
☐ Dischange:
☐ Watery ☐ Mucousy
☐ Purulent ☐ Green-coloured
☐ Frequent sinusitis

Tonsils

☐ Operation
☐ Frequent tonsillitis:
☐ As a child ☐ Nowadays

Thyroid

☐ Known Hyperthyroid
☐ Known Hypothyroid
☐ Enlarged
☐ Operation
☐ Other:

8 Breasts • Stomach • Back

Breasts / mammary glands

☐ Complaints ☐ Operations

Heart

☐ Complaints
☐ Stabbing pains
☐ Sensation of pressure
☐ Heart attack
☐ Anxiety
☐ Arrhythmia
☐ Angina pectoris

Lungs

☐ Bronchitis ☐ Frequent cough ☐ Shortness of breath

Liver

☐ Inflammation ☐ Hepatitis

Gallbladder

☐ Stones ☐ Colics ☐ Operation ☐ Pressure in the upper abdomen ☐ Fat intolerance

Stomach

☐ Bloating ☐ Gastritis ☐ Lack of appetite ☐ Food allergies/intolerances

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Back

☐Pain ☐Lumbago ☐Sciatica ☐Scoliosis

Kidney/bladder

☐Kidney stones ☐Inflammation ☐ Frequent:

Urine

☐A lot ☐Frequent

☐Little ☐Cannot hold it

☐Smells of:

Intestines

☐Infections ☐Appendix removed

☐Haemorrhoids ☐Bloating

Stool

☐Daily ☐Every second day ☐Irregular ☐Tendency to constipation ☐Tendency to diarrhea

☐Smells of:

Stool consistency

☐Light ☐Hard ☐Greasy ☐ Feeling of not being able to fully pass stool

☐Dark ☐Knobbly ☐Paste-like

☐Foul Smelling ☐Soft ☐Cannot hold stool

9 Arms • Legs • Back • Skin

Arms

☐Injuries ☐Pain ☐Tennis elbow ☐Pins and needles ☐Cold hands

Legs

☐Pain ☐Varicose veins ☐Operations ☐Injuries ☐Cold feet ☐Pins and needles ☐Numbness

Back

☐Impaired mobility ☐Tension ☐Strain ☐Rheumatism

Skin/nails

☐Burns ☐Itching ☐Ingrown nails

☐Scars ☐Warts ☐Inflammation of the nailbed

☐Ulcers ☐Fungus ☐Allergies to:

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10 Gynaecological/urological area

Gynaecological

☐ Pain ☐ Miscarriages ☐ Tumours ☐ Venereal diseases

☐ Inflamm. of the ovaries ☐ Births, no.: ☐ Cysts

☐ Curettage of the uterus ☐ Abortions ☐ Fibroids

Discharge

☐ None ☐ Heavy ☐ White ☐ Yellow ☐ Damages the skin ☐ Discoloured underwear

Periods

When was your first period? Your last?

How long is your period? How long is your cycle?

(1 .day of your last period until the day prior to the next period e.g. 27 days)

Bleeding is

☐ Light ☐ Clumpy ☐ Regular

☐ Dark ☐ Brown ☐ Irregular

Prostate

☐ Enlarged ☐ Difficulties urinating

☐ Inflammation ☐ Venereal diseases

Sexuality

☐ Low libido ☐ Satisfied ☐ Dissatisfied

☐ High libido ☐ Fulfilled sexual life ☐ Non-fulfilled sexual life

☐ Difficulties during sexual intercourse

11 Radiation exposure

Do you use a mobile phone? ○ Yes ○ No

If so: How many minutes do you use it each day?

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Each day about _____ Minutes

Since: _____ ○ Month / ○ Years. ○ With ○ Without headset ○ Both

○ It is switched on about _____ minutes a day / ○ Always switched on

Where do you wear it? _____

Do you own a DECT-telephone (cordless fixed telephone) ○ Yes ○ No

If so, how many minutes do you use it each day? Each day about _____ Minutes

Since: _____ ○ Month / ○ Years. ○ With ○ Without headset ○ Both

Which brand and/or model? _____

Do you use any wireless LAN connections ? ○ Yes ○ No

If so:

How many minutes each day?

Each day about _____ Minutes

Since: _____ ○ Month / ○ Years.

○ It is switched on about _____ Minutes a day / ○ Always switched on

Railway

Distance from your house / flat to the next railway station: About _____ km

Telephone pole / radio mast

Distance from your house / flat to the next telephone pole / radio mast or radar station? About _____ km

Since when do you live cin that distance to it? _____ ○ Weeks ○ Month ○ Years

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12 Space for further information:

☐ I hereby agree that my case documentation including laboratory results may be made available (in sanitised form) to other therapists and scientific institutions.

Date, place, signature of the patient

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