



Data and medical history

To prepare for your treatment / consultation

Dear Patient,

You will soon be receiving treatment at our clinic. This questionnaire is designed to document your medical history. This will help us gain a comprehensive understanding of your symptoms and identify any conditions outside the field of urology.

We ask that you carefully complete this questionnaire in advance of your consultation or treatment. This will give you the opportunity to consider all the important questions without time pressure. Of course, you will also have an initial consultation with a doctor and nursing staff, as well as a physical examination.

Last Name: _____ First Name: _____

Date of Birth: _____ Height: _____ cm Weight: _____ kg

Occupation: _____ Are you retired? ☐ Yes ☐ No

Street: _____ ZIP Code/City: _____

Privat phone number: _____

Mobile number: _____

Email address (preferably a personal one): _____

Family member / Contact person
during your stay at the Martini-Klinik _____

Mobile phone number of the family member/contact
person during your stay at the Martini-Klinik _____

General information

Your urology practice: _____

Your primary care physician's office: _____

Other treating physicians: _____

Are you following a special diet? ☐ Yes ☐ No

If yes, which one? _____

_____ Since _____

Do you provide for yourself? ☐ Yes ☐ No

If no, do you need help with:

☐ Eating/Drinking ☐ Getting dressed
☐ Washing/Personal hygiene ☐ Using the restroom

Do you wear a hearing aid? ☐ Yes ☐ No

Do you wear contact lenses or glasses? ☐ Yes ☐ No

Do you wear removable dentures? ☐ Yes ☐ No

Do you have limited mobility? ☐ Yes ☐ No

If so, do you need assistive devices?

☐ Walking aid ☐ Wheelchair

Do you exercise regularly? ☐ Yes ☐ No

Are you or have you been exposed to harmful substances? ☐ Yes ☐ No

If yes, which one?

Do you drink alcohol regularly? ☐ Yes ☐ No

If so, which one?

Amount _____ ☐ per day / ☐ per week

Are you a smoker? ☐ Yes ☐ No

☐ No, never

☐ No, I quit _____ years ago

☐ Yes, for _____ years, _____ cigarettes a day

Is there any other regular use of addictive substances? ☐ Yes ☐ No

If yes, which one?

Medical history

Do you take medication? ☐ Yes ☐ No

Medication / Dosage	morning	at noon	evening	night	as needed
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

Are you taking any blood-thinning medications?

(e.g., aspirin (ASA), clopidogrel, Eliquis, heparin, Lixiana, Marcumar, Plavix, Pradaxa, Xarelto)
If you take aspirin (ASA), please specify the dosage _____ mg

Do you take:

Cortisone preparations ☐ Yes ☐ No
regularly sleeping pills ☐ Yes ☐ No
regularly laxatives ☐ Yes ☐ No

Pre-existing conditions

[1] Infectious disease? Do you have or have you ever had any of the following?

Hepatitis B ☐ Yes ☐ No
Hepatitis C ☐ Yes ☐ No
HIV (AIDS) ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No
Is the diagnosis more than six months old? ☐ Yes ☐ No

[2] Have you ever received a blood transfusion?

☐ Yes ☐ No

Cardiovascular risk profile

1. Heart disease

arrhythmias ☐ Yes ☐ No
heart attack ☐ Yes ☐ No
coronary artery disease (CAD) ☐ Yes ☐ No
heart valve defects ☐ Yes ☐ No
Myocarditis or
valvitis Heart failure ☐ Yes ☐ No
Cardiac insufficiency ☐ Yes ☐ No
Angina pectoris (episodic) ☐ Yes ☐ No

2. Cardiac procedures

bypass surgery ☐ Yes ☐ No
cardiac catheterization/stent(*) ☐ Yes ☐ No
Heart valve surgery ☐ Yes ☐ No

3. Heart failure

Shortness of breath, chest pain on exertion (e.g., climbing several flights of stairs), sensitivity to cold? ☐ Yes ☐ No
Leg edema (fluid in the legs) ☐ Yes ☐ No

Other _____

If you answered "yes" to any of these questions:

Please bring the test results with you to your next appointment.

Is the most recent cardiology report more than six months old? ☐ Yes ☐ No

If so, further evaluation with a stress ECG and echocardiogram is necessary. Ideally, you should schedule an appointment with your cardiologist right away.

(*) Note: For drug-eluting stents, surgery is only possible six to twelve months after stent implantation. Please discuss this with your cardiologist.

Hospital-acquired infections risk profile

This concerns multidrug-resistant pathogens (bacteria and fungi): **MRSA** (methicillin-resistant Staphylococcus aureus), **4MRGN** (multidrug-resistant Gram-negative bacteria).

It is important to know whether you—knowingly or unknowingly—are a carrier of such a pathogen. While they are harmless in healthy people, they can lead to serious infections in wounds or in immunocompromised individuals.

Have you ever been diagnosed with a **MRSA**, **4MRGN**, pathogen or a **Candida auris fungus**?

☐ MRSA ☐ 4MRGN ☐ No

Have you knowingly been in contact with a person who has been diagnosed with a fungal infection or bacterial infection?

☐ MRSA ☐ 4MRGN ☐ No

Have you been hospitalized for more than three days in the past 12 months?

☐ Yes ☐ No

Outside of Germany?

☐ Yes ☐ No

Do you live in Southern Europe, Great Britain or outside of Europe? ☐ Yes ☐ No

Have you knowingly had contact with someone carrying the MRSA bacterium? ☐ Yes ☐ No

Do you have occupational contact with farm animals? ☐ Yes ☐ No

Are you a dialysis patient? ☐ Yes ☐ No

Do you have chronic wounds? ☐ Yes ☐ No

Do you require nursing care, and have you received antibiotic treatment in the past 6 months? And/or an indwelling catheter? ☐ Yes ☐ No

Do you need a feeding tube? ☐ Yes ☐ No

If you answered “yes” to any of these questions:

we ask you to perform a screening (**nasal swab for MRSA, anal- and groin swab for MRGN**).

Please send the results **latest 14 days prior** to your operation.

[3] Do you have any known allergies?

☐ Yes ☐ No

Allergy	Since	Reactions

Do you have an allergy card? Please bring it with you when you check in.

[4] Circulatory and vascular diseases

Thrombosis	☐ Yes	☐ No
Embolism	☐ Yes	☐ No
Varicose veins	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Circulatory disorders	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No

Other _____

[5] Respiratory and lung diseases

Asthma	☐ Yes	☐ No
Chronic bronchitis	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Cough or cold with a fever	☐ Yes	☐ No
Sleep apnea syndrome	☐ Yes	☐ No
Do you sleep with a mask?	☐ Yes	☐ No

Other _____

[6] Liver diseases

Fatty liver	☐ Yes	☐ No
Cirrhosis of the liver	☐ Yes	☐ No
Elevated liver enzymes	☐ Yes	☐ No
Gallstones	☐ Yes	☐ No

Other _____

[7] Digestive tract

Pancreatitis	☐ Yes	☐ No
Crohn's disease	☐ Yes	☐ No
Ulcerative colitis	☐ Yes	☐ No
Stomach ulcer	☐ Yes	☐ No
Gastroesophageal reflux disease	☐ Yes	☐ No
Gastritis	☐ Yes	☐ No
Intestinal polyps	☐ Yes	☐ No
Diverticula	☐ Yes	☐ No
Hemorrhoids	☐ Yes	☐ No
Tendency toward constipation	☐ Yes	☐ No
Nausea / Vomiting	☐ Yes	☐ No
Blood in the stool	☐ Yes	☐ No
Unintentional weight loss	☐ Yes	☐ No

If yes, how much, how fast _____ kg _____ Months

Other _____

[8] Metabolic disorder

Diabetes	☐ Yes	☐ No
High Blood Lipid Levels	☐ Yes	☐ No
Hyperthyroidism	☐ Yes	☐ No
Hypothyroidism	☐ Yes	☐ No

Other _____

[9] Eyes

Retinal detachment	☐ Yes	☐ No
Cataract (clouding of the lens)	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No

Other _____

[10] Nervous and mental disorders

Epilepsy	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Schizophrenia	☐ Yes	☐ No
Migraine	☐ Yes	☐ No

Other _____

[11] Skeletal or muscular disorders

Bone or muscle wasting	☐ Yes	☐ No
Bone fractures	☐ Yes	☐ No
Degenerative joint disease (osteoarthritis)	☐ Yes	☐ No
Rheumatism	☐ Yes	☐ No
Herniated disc	☐ Yes	☐ No
this was treated	☐ surgically	☐ conservatively

Other _____

[12] Blood

☐ Yes ☐ No
Deficiency of red blood cells
☐ Yes ☐ No
Low white blood cell count
☐ Yes ☐ No
Low platelet count
☐ Yes ☐ No
Blood clotting disorder

Current hemoglobin level (Hb level) _____

Other _____

[13] Urine and urination

☐ Yes ☐ No
Pain when urinating
☐ Yes ☐ No
Frequent urge to urinate
☐ Yes ☐ No
Do you have blood in your urine?

Yes, since _____

How often do you urinate?

During the day: _____ times at night: _____ times

☐ Yes ☐ No
Is there a problem with the urine stream?

Yes, since _____

☐ Yes ☐ No
Do you suffer from involuntary urine leakage?

☐ Yes ☐ No
Have you ever had urinary retention?

☐ Yes ☐ No
Are you currently using an indwelling catheter?

If so, please have your urologist test your urine for germs and bacteria two weeks before admission so that antibiotic treatment can be started immediately in the event of a urinary tract infection.

[14] Previous urological conditions

Date	Disease	Clinic

Do you require dialysis? ☐ Yes ☐ No

[15] Urological surgeries, other surgeries, and hospital stays

Date	Surgery	Hospital

[16] Other cancers Date of diagnosis / type of cancer (location)

[17] History of your prostate cancer PSA history

Please enter your PSA levels from the past few years in chronological order in the table below:

Date	PSA	Date	PSA

Hormone therapy

Have you already started anti-hormonal treatment? ☐ Yes ☐ No

If yes, since when and which medication?

for	Medication	Dosage?

[18] Familienanamnese

Is there or has there been a history of cancer in your family? (Blood relatives: grandparents, mother, father, uncles, aunts, siblings, children) ☐ Yes ☐ No

In whom	What type of cancer	Diagnosed at age of

Has your family ever undergone genetic testing to determine whether there is a family history of prostate, ovarian, or breast cancer, or were any abnormal results found? ☐ Yes ☐ No

Date: _____ Signature: _____