azb
arbeitsmedizinisches zentrum basel

# Medical Questionnaire – StVA/MFK

**Name, First name:** ..... **Date of birth:** .....

**Employer:** ..... **Occupation:** .....

**Family status:** ..... **Children:** .....

**Sports, hobbies:** .....

**Ticket category:**
- ☐ **Car, motorbike** **since:** .....
- ☐ **Truck** **since:** .....
- ☐ **Bus** **since:** .....

**Annual kilometer performance:** .....

**Impact of driving practice in the area of rail or road (accidents, traffic buses, ticket withdrawals, etc.):**

| Time | Type of event |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**Last medical examination for driving license:** ..... **at whom?** .....

**Have you ever been declared unfit to drive I motor vehicles?** ☐ no ☐ yes

If so: when? ..... examining doctor: ..... reason: .....

**Have you been declared <u>un</u>fit for military service?** ☐ no ☐ yes

if so: for what reason? .....

**Actual health situation**

**Do you actually suffer from a medical condition?** ☐ no ☐ yes

if so: what of? .....

**Are you actually taken care of by a physician and/or a psychotherapist, a physiotherapist?** ☐ no ☐ yes

If so: for what reason(s) (diagnosis)? .....

**Ladies: Are you pregnant?** ☐ no ☐ yes

**Do you wear glasses/contact lenses?** ☐ no ☐ yes if yes - correction for: ☐ distance ☐ proximity

**Do you smoke?** ☐ no ☐ yes if yes: since when? ..... what? .....
☐ no - stopped if applicable: when did you stop, how many years & how much did you smoke? .....

**Alcoholic beverage?** ☐ no ☐ yes if yes: what kind of, how much & frequency? .....

**Do you consume drugs?** ☐ no ☐ yes if yes, what kind of, how much & frequency? .....

**Please mention ALL medication that you take actually - including "the pill":**

.....

**Past Medical History**

Please mention **all medical conditions** of which you have been suffering from and also, **when**
... **severe medical conditions** (e.g. cardio-vascular-diseases, stroke, cancer, etc.),
... **surgery** (e.g. tonsils, appendicitis, inguinal hernia, intervertebral disc, eyes, etc.), or
... **accidents, injuries** (e.g. fractures, torn ligaments, Injuries of the eyes or ears, etc.).

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***please turn over***

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**Past Medical History (organ systems)**

**Have you ever suffered from /Do you suffer from:**
if so: please underline what is applicable.

| | |
|---|---|
| epilepsy, giddiness, loss of consciousness, memory disorder, chronic headache, migraine, palsies, balance disorder etc. | ☐ no ☐ yes |
| heart insufficiency, acute cardiac infarction, angina pectoris, disorders of heart beat, high / low blood pressure, collapse, disorders of (peripheral) arteries / veins etc. | ☐ no ☐ yes |
| bronchial asthma, chronic bronchitis, pneumonia / pleurisy, lung tuberculosis etc. | ☐ no ☐ yes |
| gastric disorders (e.g. ulcers, inflammations, reflux), intestinal diseases (e.g. inflammations [Crohn's disease], diverticulitis, anal fistula, haemorrhoids; polyps), gall stone, liver diseases, pancreatitis etc. | ☐ no ☐ yes |
| metabolic disorders (e.g. diabetes, high cholesterol, gout, thyroid gland disorders, intolerance to lactose or to gluten etc.) | ☐ no ☐ yes |
| psychiatric disorders, vertigo, claustrophobia, depression, suicide attempt, drug dependence, withdrawal therapy [alcohol, illicit substance, medical drugs) | ☐ no ☐ yes |
| sleep disorders, snoring, respiratory pauses during sleep, increased fatigue during daytime | ☐ no ☐ yes |
| hearing problems (e.g. sudden hearing loss, ear buzzing, hardness of hearing etc.)<br>eye problems (e.g. glaucoma, cataract, retinal detachment etc.) | ☐ no ☐ yes |
| blood disorders (e.g. anaemia etc.), disorders of blood clotting, swollen lymph nodes, | ☐ no ☐ yes |
| disorders of the vertebral column (e.g. lumbago, disc hernia, scoliosis etc.) | ☐ no ☐ yes |
| bone, joint (e.g. arthrosis, rheumatism etc.), or muscle disorders | ☐ no ☐ yes |
| kidney disorders (e.g. cysts, infections, inflammations, stones, malformations etc.) | ☐ no ☐ yes |
| allergies (e.g. pollen, pet animals, lab animals, insect bites, medical drugs etc.) or skin disorders (e.g. eczema, psoriasis, tumour etc.) | ☐ no ☐ yes |

**With signing the form I confirm having filled it out with care and that I did neither suppress nor give false information.**
**At the same time, I authorize my doctors to provide information and / or transfer of medical documents to the examining doctor.**

Place and date: Signature:

Please do not fill out the fields below!

***Dokumentation durch AMPA:***

| | | |
|---|---|---|
| Datenerfassungsbogen | | ☐ (in Akte vorhanden ? ☞ ggf. ausfüllen lassen) |
| Kopie Ausweis | | ☐ |
| Kopie Brillenpass | | ☐ |
| Fakt. | | ☐ (ins Medistar eingeben!) |
| Biometrie | | Grösse …….. cm Gewicht …… kg |
| Urinstatus (Combur 7) | | pH ..... /..... |
| Flüsterzahlen | re | ☐ oB ☐ auffällig |
| | li | ☐ oB ☐ auffällig |
| Rodatest | | ☐ |