

Medical Questionnaire – StVA (MFK)/ Inland shipping

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 unfit 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":

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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

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.)	☐ no ☐ yes
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!)

Urinstatus (Combur 7) pH /
 Flüsterzahlen re ☐ oB ☐ auffällig
 li ☐ oB ☐ auffällig
 Rodatest ☐