ANAMNESTIC QUESTIONNAIRE Dept. of Rehabilitation and Physical Medicine at the Na Homolce Hospital

Surname and First Name, Title: Birth No.:			Personal Identification Code
Occupation:	Incapacity for Work ☐ Yes ☐ No		
Phone: **E-mail:**	Height (cm):	Weight (kg):	

Please fill in the following information (put an X in ☐, fill in the blank here or on the other side):

Cardiac stimulator	☐ yes	☐ no
Bleeding conditions, taking blood thinners. Please state:	☐ yes	☐ no
Tumour diseases. Please state:	☐ yes	☐ no
Metal bodies in the body. What and where:	☐ yes	☐ no
Endocrine diseases: thyroid, adrenal, hypothalamus, pituitary (pituitary gland), pancreas (diabetes)... Specify:	☐ yes	☐ no
Neurological disorders (stroke, multiple sclerosis, myasthenia, epilepsy,...). Please state:	☐ yes	☐ no
For women: Date of the last menstruation: Are you pregnant?	☐ I don't know	☐ yes ☐ no
Heart disease (aneurysm, heart defect, ischaemic disease, rhythm disorder) Please state:	☐ yes	☐ no
High blood pressure	☐ yes	☐ no
Diseases of the blood vessels (ischaemic disease of the lower limbs, venous inflammation, varicose ulcer, varicose veins, thrombosis, ...). Please state:	☐ yes	☐ no
Diseases of the respiratory system. Please state:	☐ yes	☐ no
Rheumatological diseases. Please state:	☐ yes	☐ no
Diseases of the digestive tract (liver, pancreas, ulcer disease, ulcerative colitis...) Specify:	☐ yes	☐ no
Glaucoma	☐ yes	☐ no
Skin diseases (eczema, formations on the skin...). Please state:	☐ yes	☐ no
Mental disorders. Please state:	☐ yes	☐ no
Injuries, surgeries. Please specify which operations and when:	☐ yes	☐ no
Are you taking medications? Which:	☐ yes	☐ no
Other diseases. Please state:	☐ yes	☐ no
Do you have an allergy? Specify (especially for medications!):	☐ yes	☐ no

Please continue to fill in the questionnaire on the second page →→→

Please provide information related to your visit to the Department of Rehabilitation and Physical Medicine:

What is the reason, the purpose of your visit?	
I'm having difficulties	☐ after an accident (specify) : _____ ☐ after a surgery (specify): _____ ☐ other reasons (please specify): _____
Duration of the difficulties	☐ 1-7 days ☐ 1-3 weeks ☐ 3-9 weeks ☐ 2-3 months ☐ 3-7 months ☐ 7-12 months ☐ longer – please specify how long:
What would I like to achieve through rehabilitation?	

If you are undergoing treatment for an illness outside the NHH, please bring copies of medical reports to be examined by a rehabilitation physician!

Current pain level – select the number on the scale that best matches the intensity of your pain:

no pain										*the highest possible pain*
0	1	2	3	4	5	6	7	8	9	10

What activities are most limited by your disability / pain:

For injuries and surgeries of the musculoskeletal system, indicate the limitations expressed by another specialist (orthopaedist...) E.g. after lower limb surgery, please indicate the degree of allowed weight-bearing on the operated limb in standing position (in % or in kg, etc.), the range of allowed movement in the affected joint…

Space for Additional Data:

Patient Instruction, Department of Rehabilitation and Physical Medicine. By signing this form I confirm the accuracy of the information provided and undertake to follow the Patient Instructions of the Department of Rehabilitation and Physical Medicine. The instructions are available at the ward reception and each patient is obliged to read and follow the instructions. Failure to follow these guidelines may result in your booked procedure dates being released for other patients due to capacity reasons.

In Prague, Date: ……..…… Patient's signature: ……..……