

Marinefliegergeschwader 3 „Graf Zeppelin“

Questionnaire to your state of health

Name, given name: _____ Date of birth: _____

Participating organization: _____ (Fire brigade, etc)

Job title: _____

	No	Yes
Are you currently under medical/dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, give reason _____		
Do you have regular company medical check-ups?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, which check-ups _____		
Are there any familial diseases like heart disease, hypertension, diabetes or other illnesses?		

Have you already suffered from:	No	If yes,when?
Cardiovascular diseases? (Hypertension, dizziness, heart attack)	<input type="checkbox"/>	<input type="checkbox"/> _____
Lung diseases? (asthma, bronchial asthma, lung injuries)	<input type="checkbox"/>	<input type="checkbox"/> _____
Allergies? (Hay fever, allergic asthma, foodstuff, drugs & medicaments)	<input type="checkbox"/>	<input type="checkbox"/> _____
Vertebral column & articulation diseases? (Herniated disk)	<input type="checkbox"/>	<input type="checkbox"/> _____
Abdominal viscus diseases? (Stomach ulcer)	<input type="checkbox"/>	<input type="checkbox"/> _____
Metabolism diseases? (Diabetes, thyroid hypo-/hyperfunction)	<input type="checkbox"/>	<input type="checkbox"/> _____
Injuries or accidents? (Concussion with or without awareness)	<input type="checkbox"/>	<input type="checkbox"/> _____
Neurological or psychiatric diseases? (Convulsions, agoraphobia)	<input type="checkbox"/>	<input type="checkbox"/> _____
ENT diseases (ear-nose-throat)?	<input type="checkbox"/>	<input type="checkbox"/> _____
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/> _____

	No	Yes
Do you take medicaments regularly?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, which kind of medicaments and for what reason?		

Do you take exercises regularly?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, which kind of exercises and how often?		

Do you dive?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have currently a cold?	<input type="checkbox"/>	<input type="checkbox"/>
Any additional particulars?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, which particulars?		

I assure of answering all questions completely and correctly.

_____, _____
Place Date

Signature