



## Medical History Questionnaire

**HEIDELBERG**  
UNIVERSITY  
HOSPITAL

Please read the following questions carefully and answer them correctly.  
**When completed, please send the questionnaire to**  
**e-health.med5@med.uni-heidelberg.de**

### Personal data of the patient:

Last Name\*

First Name\*

Date of birth\*

Gender (m, f, diverse)

### Address Details

Country of  
residence\*

City and  
postal code\*

Phone number\*

Email address\*

### Contact details of supporting person filling in this questionnaire:

*(if patient is not filling in the questionnaire himself / herself)*

Last Name\*

First Name\*

I am the

Relationship  
to patient\*

- daughter / son
- mother / father
- friend
- other (please specify):

Phone number\*

Email address\*

\* mandatory

## Medical Information

Please select your main diagnosis:

- Multiple myeloma
- Lymphoma
- Sarcoma
- CUP Syndrome
- Acute Lymphocytic Leukemia (ALL)
- Acute Myeloid Leukemia (AML) /Myelodysplastic Syndrome (MDS)
- Myeloproliferative Syndrome (MPS)
- Monoclonal Gammopathy of Unknown Significance (MM/ MGUS)
- Chronic Myelogenous Leukemia (CML)
- Other, Specify:

.....

Which diagnostic tests were performed during the last 3-6 months?

- MRT
- CT/PET-CT
- Sonography
- X-ray
- Angiography
- Heart catheter
- Endoscopy (Gastroscopy, Colonoscopy, Bronchoscopy, etc.)
- Bone marrow aspirate
- Bone marrow biopsy
- Lymph node biopsy
- Other, please specify other diagnostic tests:

.....

Which laboratory tests were performed during the last 3-6 months?

- Routine Tests (e.g. blood count)
- Genetic Tests (Cytogenetic/ FISH)
- Molecular biological Tests (sequencing for genetic mutations)
- Special Tests, please specify:

.....

Was a Histology test taken?

- Yes

Tissue sample was taken on (DD/MM/YYYY): .....

- No

Which treatments have been performed?

- None
- Operation/ Intervention (e.g. heart catheter)
- Drug Therapy (e.g. Chemotherapy, other medication)

Please list ongoing treatments with the date the treatment was started

.....

- Irradiation

Please list ongoing treatments with the date the treatment was started

.....

- Other (please specify)

.....

Please indicate any further relevant diagnosis:

Do you have any infections at present?

- Yes

Which pathogenic agent: .....

- No

Do you have any open wounds at present?

- Yes

Please specify location: .....

- No

Please describe your current mobility status:

Would you like to share any additional information that can be useful for assessing your case (e.g. contact data of treating physician):

## Selection of service

Which service would you like to receive?

- Second opinion in a written report (provided in German or English)
- Second opinion in a Video consultation (including written report)

The video consultation will be held in German or English. Will you need an interpreter?

- No
- Yes
  - Russian
  - Arabic
  - Spanish
  - Chinese
  - Other (please specify):

What are your expectations from obtaining a second medical opinion from Heidelberg University Clinic?

How did you learn about Heidelberg University Hospital?

- Internet
- Business partners
- Employer
- Heidelberg University Hospital staff member
- Press releases
- Health insurance
- Treating physician /hospital
- Family members / friends
- Embassy/ Governmental institution
- Other, please specify:

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