**Bitte beantworten Sie folgende Fragen**

**Praxis Dr. Alexander Heinl**  
Hindenburgstraße 35  
55 118 Mainz  
Tel: 06131-674081  
Fax: 06131-674082

E-Mail: [praxis.heinl@gmail.com](mailto:praxis.heinl@gmail.com)

**www.allgemeinarzt-mainz.de**

|  |  |
| --- | --- |
| Nachname |  |
| Vorname |  |
| Geboren am |  |
| Rückruf-Telefonnummer |  |
| E-Mail |  |
| Straße & Hausnummer |  |
| PLZ & Ort |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Zeitpunkt der Beschwerden** | Vor 4 Tagen | | Vor 3 Tagen | | Vor 2 Tagen | | | Gestern | | | | | | | | Heute | | | | | | | | | | |
| Bitte Ja oder Nein ankreuzen | Ja | Nein | Ja | Nein | Ja | Nein | | Ja | | | | | Nein | | | Ja | | | | | Nein | | | | | |
| Waren Sie im Ausland |  |  |  |  |  |  | |  | | | | |  | | |  | | | | |  | | | | | |
| Wenn ja, von wann bis wann? |  | | | | | |  | |  | |  | | |  |  | | |  | |  | |  | |  | |
| Wenn ja, wo/an welchem Ort? |  | | | | | | | | |  | |  | | |  | |  | |  | | | |  | |  | | |  |  |

|  |  |  |
| --- | --- | --- |
| Bitte Ja oder Nein ankreuzen | Ja | Nein |
| Hatten Sie in den letzten 14 Tagen körperlichen Kontakt zu einem Corona-Virus-Erkrankten od. einem Verdachtsfall? |  |  |
| Hatten Sie in den letzten 14 Tagen beruflich oder privat persönlichen Kontakt zu Kindern, Jugendlichen oder Erwachsenen, bei Veranstaltungen, Meetings oder in öffentlichen Verkehrsmitteln? |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Zeitpunkt der Beschwerden** | Vor 4 Tagen | | | | Vor 3 Tagen | | | | | | | Vor 2 Tagen | | | | | Gestern | | | | | | | | | | | | Heute | | | | | | | | | | | |
| Bitte Ja oder Nein ankreuzen | Ja | Nein | | | Ja | | | Nein | | | | Ja | | Nein | | | Ja | | | | | Nein | | | | | | | Ja | | | | | | | Nein | | | | |
| Haben die Symptome plötzlich angefangen? |  |  | | |  | | |  | | | |  | |  | | |  | | | | |  | | | | | | |  | | | | | | |  | | | | |
| Genauer Beginn der Beschwerden am: |  | | | | | | | | | | | | | | |  | |  | |  | | |  | | |  | | | |  | | | |  | | | | | | |  | | | | |  | | |
| Haben oder hatten Sie … |  |  |  |  | |  |  | |  |  |  | |
| Fieber? |  |  | | |  | | |  | | | |  | | |  | |  | | | | |  | | | | | | |  | | | | | | |  | | | | |
| Wenn ja, wie hoch? Fieber messen & eintragen. |  | | | |  | | | | | | |  | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | |  | | | |  | |  |  |
| Trockener Husten? |  |  | | |  | | |  | | | |  | | |  | |  | | | | |  | | | | | | |  | | | | | | |  | | | | |
| Husten mit Auswurf? |  |  | | |  | | |  | | | |  | | |  | |  | | | | |  | | | | | | |  | | | | | | |  | | | | |
| Wenn ja, weiß, grün oder gelb? | Bitte Zutreffendes eintragen: | | | | | | | | | | | | | | | | | |  | |  | | | |  | | |  | | | |  | | |  | | |  | |  | | |  | | | |
| Luftnot/Kurzatmigkeit? |  |  | | |  | | |  | | | |  | | |  | |  | | | | |  | | | | | | |  | | | | | | |  | | | | |
| Herzrasen und/oder schneller Herzschlag? |  |  | | |  | | |  | | | |  | | |  | |  | | | | |  | | | | | | |  | | | | | | |  | | | | |
| Kopfschmerzen? |  |  | | |  | | |  | | | |  | | |  | |  | | | | |  | | | | | | |  | | | | | | |  | | | | |
| Halsschmerzen? |  |  | | |  | | |  | | | |  | | |  | |  | | | | |  | | | | | | |  | | | | | | |  | | | | |
| Gliederschmerzen? |  |  | | |  | | |  | | | |  | | |  | |  | | | | |  | | | | | | |  | | | | | | |  | | | | |
| Muskel- und/oder Gelenkschmerzen? |  |  | | |  | | |  | | | |  | | |  | |  | | | | |  | | | | | | |  | | | | | | |  | | | | |
| Geschmacks- und/oder Geruchsstörung? |  |  | | |  | | |  | | | |  | | |  | |  | | | | |  | | | | | | |  | | | | | | |  | | | | |
| Verstopfte Nase? |  |  | | |  | | |  | | | |  | | |  | |  | | | | |  | | | | | | |  | | | | | | |  | | | | |
| Schnupfen? |  |  | | |  | | |  | | | |  | | |  | |  | | | | |  | | | | | | |  | | | | | | |  | | | | |
| Übelkeit-Erbrechen? |  |  | | |  | | |  | | | |  | | |  | |  | | | | |  | | | | | | |  | | | | | | |  | | | | |
| Durchfall? |  |  | | |  | | |  | | | |  | | |  | |  | | | | |  | | | | | | |  | | | | | | |  | | | | |
| Rauchen Sie? Wenn ja, wie viele pro Tag? |  |  | | | Anzahl pro Tag bitte eintragen: | | | | | | | | | | | | | | | | | | |  | | |  | | | |  | |  | | | |  | |  | | |  | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Bitte Ja oder Nein ankreuzen | | | | | | | | | | | | | Ja | Nein | | |
| Sind Sie gegen Grippe geimpft? | | | | | | | | | | | | |  |  | | |
| Sind Sie gegen Pneumokokken/Lungenentzündung geimpft? | | | | | | | | | | | | |  |  | | |
| Haben Sie eine der folgenden chronischen Erkrankungen? | | | | | | | Bitte Zutreffendes im rosa Kästchen ankreuzen. | | | |  |  | |  | |  |  | |  |  |  |  |
| Bluthochdruck |  |  | Herzinfarkt |  |  | Atemwegserkrankung | |  |  | Asthma Bronchiales | | | | |  | | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| COPD-dauerhaft atemwegsverengende Lungenerkrankung |  |  | Chronische Bronchitis |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Immunsuppressive Therapie? Aktuell? |  | In der Vergangenheit? |  |  | Diabetes |  |  |  |  |