Attachment 2.1
(Regarding item I no. 2.3, sentence 2)

Anamnesis Questionnaire – Adult

(Please mark with a cross where applicable and hand over to the doctor!)
Personal data, including ZAB identification number: Date: .....

Gender: male ☐ female ☐ Nationality: ..... Pregnancy: ..... Month
Single person ☐ Family ☐

1.	Are you sick?	Yes ☐	No ☐
2.	Are you taking medication?	Yes ☐	No ☐
3.	Are you immunised against diseases?	Yes ☐	No ☐
4.	Did you undergo a skin test for tuberculosis?	Yes ☐	No ☐
5.	Do you have or have you had an infectious disease?	Yes ☐	No ☐
	Consumption (Tuberculosis)?	Yes ☐	No ☐
	Hepatitis?	Yes ☐	No ☐
	HIV?	Yes ☐	No ☐
	Chickenpox?	Yes ☐	No ☐
	Measles?	Yes ☐	No ☐
	German measles?	Yes ☐	No ☐
	Diphtheria?	Yes ☐	No ☐
	Syphilis (Lues)?	Yes ☐	No ☐
	other sexually transmitted disease?	Yes ☐	No ☐
	Typhoid, paratyphoid fever?	Yes ☐	No ☐
	Cholera?	Yes ☐	No ☐
6.	Do you have aches?	Yes ☐	No ☐
7.	Do you have or have you had a fever in the last 6 weeks?	Yes ☐	No ☐
8.	Do you have a severe cough?	Yes ☐	No ☐
9.	Are you nauseous, are you vomiting?	Yes ☐	No ☐
10.	Do you have stomach cramps or diarrhoea?	Yes ☐	No ☐
11.	Is there blood in your stool?	Yes ☐	No ☐
12.	Does it hurt when you urinate?	Yes ☐	No ☐
13.	Do you have a rash?	Yes ☐	No ☐

.....
Signature

Doctor's remark:

.....
Doctor's signature

Attachment 2.2
(Regarding item I no. 2.3., sentence 2)

Anamnesis Questionnaire - Children

(Please mark with a cross where applicable and hand over to the doctor!)
Personal data, including ZAB identification number: Date: .....

Gender: male ☐ female ☐ Nationality: ..... Age: .....

1.	Is your child sick?	Yes ☐	No ☐
2.	Is your child taking medication?	Yes ☐	No ☐
3.	Is your child immunised against diseases?	Yes ☐	No ☐
4.	Did your child undergo a skin test for tuberculosis?	Yes ☐	No ☐
5.	Does the child have or has the child had an infectious disease?	Yes ☐	No ☐
	Consumption (tuberculosis)?	Yes ☐	No ☐
	Hepatitis?	Yes ☐	No ☐
	Chickenpox?	Yes ☐	No ☐
	Mumps?	Yes ☐	No ☐
	Measles?	Yes ☐	No ☐
	German measles?	Yes ☐	No ☐
	Diphtheria?	Yes ☐	No ☐
6.	Does your child have aches?	Yes ☐	No ☐
7.	Does your child have a fever?	Yes ☐	No ☐
8.	Does your child have a severe cough?	Yes ☐	No ☐
9.	Is your child nauseous, is he/she vomiting?	Yes ☐	No ☐
10.	Does your child have stomach cramps or diarrhoea?	Yes ☐	No ☐
11.	Does your child have a rash?	Yes ☐	No ☐

.....
Signature

Doctor's remark:

.....
Doctor's signature