Points	Questions
Basic patient-related data	
1	Family status, profession
2	Height & weight (risk factor for diabetes and hypertension; weight fluctuations)
Current reason for consultation	
2	What exactly brings you in today? / What can we do for you?
Specific somatic anamnesis	
	Current complaints and development
2	Temporal occurrence, rhythm, duration
2	Name and localization of the complaints
2	Quality, degree of severity, and course of complaints
2	Conducted actions and subjective theory of disease
	Focused pain anamnesis
1	“Are you experiencing any pain?”
2	Localization of pain (located / radiating)
2	Temporal occurrence and duration of pain (beginning, wavelike / pulsating)
2	Quality of pain (burning / dull)
2	Pain intensity (strength / extent)
2	Attendant symptoms (edemas, vertigo, nausea, syncope)
2	Pain provoking or analgesic circumstances
2	Influenceability of the pain
General somatic anamnesis	
	Previous illnesses
2	Cardiovascular, metabolic, pulmonary / bronchial, digestive and neurological diseases
1	Infectious diseases and mental / psychiatric conditions
	Past medical history
1	Hospitalization, operations, accidents
2	Allergies, drug intolerances
2	Current / past medication intake and nutritional supplements
1	Travel history / stays abroad
Vegetative anamnesis	
1	Appetite, thirst, weight changes, fever, night sweat, nausea
1	Cough, sputum, digestion, urination, sleep
Risk factors	
1	Alcohol and drug consumption
1	Dietary habits, exercise, visits to the doctor, (preventive) medical check-ups
Cardiovascular risk factors	
2	High blood pressure, diabetes, hypercholesterolemia, heart diseases, stroke
2	Pre-existing conditions in the family
2	Smoking habits, lack of exercise, overweight
Family and social anamnesis	
1	Family status, psychosocial stressors, medical power of attorney, living will, patient-related release from the duty of confidentiality
Orienting psychiatric anamnesis	
1	Current mental condition