

Health Data Reporting and Recordkeeping in Early Modern Transylvania: The Medical Reports of Andrea Carol Grosse

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Abstract. This study explores the emergence of systematic health data reporting and recordkeeping in early modern Transylvania through an analysis of Andrea Carol Grosse's medical report on the 1737–1738 plague outbreak. Against the backdrop of the Habsburg Monarchy's increasing centralization and the concomitant recognition of population health as a cornerstone of military strength and economic prosperity, Grosse's work illustrates the early integration of empirical observation with nascent statistical methods. His report, structured in three interrelated sections—descriptive analysis, detailed patient case studies, and a travel diary—demonstrates how paper-based administrative technologies facilitated the collection and organization of health data. Grosse's systematic documentation of disease transmission, symptomatology, and outcomes not only reflects contemporary theories of contagion and miasma but also anticipates modern epidemiological approaches by linking individual patient histories to broader public health measures. By contextualizing Grosse's observations within the broader shifts in statecraft, medical practice, and administrative technology, this paper contributes to our understanding of how early modern health data practices laid the groundwork for the development of medical statistics and evidence-based public health policy. The findings underscore the transformative role of health data in early modern governmental strategies and offer new insights into the interplay between medical knowledge production and state power.

Keywords: Transylvania, health data, eighteenth century, epidemics, patient history

1. Introduction

During the eighteenth century, the early modern state increasingly recognized the importance of maintaining the population's health as a critical factor for its strength and prosperity. This realization has been linked in historiography to the emergence of public health initiatives, which marked the beginning of systematic efforts to sustainably improve the health of entire populations.

Health data played a crucial role in this process. Research into the relationship between population and health data in early modernity has garnered significant scholarly attention and sparked debates (Mackenbach 2020: 8-10). Key factors such as nutrition, medical advancements, hygiene, and inoculation/vaccination have been identified as foundational for improving public health and extending life expectancy. The observation and control of health during this period were facilitated by new modes of governmentality and the development of data sets to lay the foundation for public health measures. These data sets were produced on demand by the early modern state or, in some cases, by the church, reflecting a growing institutional interest in health management, but also the role of private initiative by medical practitioners.

This article examines early modern governmental modes of action for managing and collecting health-related data, focusing on the Habsburg province of Transylvania, administered by the Viennese Court, as a case study. Concentrating on a bubonic plague outbreak in 1737 and the work of Andrea Carol Grosse, it explores the modes of health data reporting and recordkeeping characteristic of the early modern period. Grosse's medical report will be analyzed as an important step toward the emergence of a medical statistic, including a glimpse toward the role of patients' histories for such new modes to gain knowledge on medical issues, to react timely during a period of medical crisis.

2. Health data between paper technology and epidemics

The relationship between the Habsburg Monarchy, as an early modern increasingly centralized organization, striving for uniformity, and its human population underwent significant changes during the eighteenth century. During this period, the Habsburgs' average population came to be recognized as important, valuable, and characterized by their occupational roles as hard-working farmers, industrious laborers, battle-ready soldiers and mothers. This shift was influenced by the rise of rational thinking among early modern states, supported by the early spread of Enlightenment ideas. States began to understand their populations as a critical factor in their wealth, as cameralism—the predominant economic theory of the time—assumed that economic

prosperity relied on the labor of men and women, who also served as valued taxpayers. Furthermore, the power of early modern states, on the cusp of transitioning into territorial states, was closely tied to military strength, which depended on having sufficient healthy soldiers. Consequently, diseases, which decimated the population, became not only a demographic issue but also an economic and security problem. The Habsburg Monarchy began to take on the role of a manager of public health, collecting health data for self-serving purposes. Historiography previously pointed to the emergence of state-institutionalized public health in the nineteenth century and classified developments such as the formation of statistics as prerequisites for the establishment of public health. An approach that Dorothy Porter, especially since the fight against epidemics has been regarded as part of public health, classified as outdated. The handling of epidemic diseases must be viewed as part of an emerging modern governmentality of health (Porter 1999: 10).

The long eighteenth century was characterized by the “epidemiological transition”, a phase in which pestilence and famine were the leading causes of death among contemporaries. The predominance of pestilences—often in the context of wars—began to shape governmental strategies aimed at both preventing and curbing epidemic diseases (Mackenbach 2020:7-8).

The frequent occurrence of epidemics also sparked a broader interest in the issue of public health. The “fight” against epidemics became an integral part of both the external and internal policies of the Viennese Court, serving as a foundational element of governmental strategy (Lesky 1957: 82-106; Jesner 2021: 31–55). The Habsburg Monarchy established new institutions such as the *Sanitätshofkommission* (Sanitary Court Commission) based in Vienna, the *Sanitätskommissionen* (Sanitary Commissions) in the provinces – in Sibiu, and the *Medicinal Polizey* (medical police), which acted as a significant surveillance authority. The medical police monitored the population’s behaviour, particularly regarding sexual conduct, which the Roman Catholic Habsburg leadership regarded as crucial for public health by preventing the spread of sexually transmitted diseases (Rosen 1974, Rosen 1958, Möller 2005, Lang 2021).

The early modern state also created new professional roles, such as *proto medici* (leading physicians) and *(pest)chirurgi* (specialists for pestilences), to manage and implement health and sanitary policies. These processes are of particular interest because they facilitated the collection of new health-related data. These measures were accompanied by new laws (Sanitätsnormativ 1770), the establishment of medical spaces (e.g., terrestrial and maritime quarantine stations, hospitals, and homes for invalids), new hygiene strategies (e.g.,

canalization, the promotion of clean water, purification methods, and social distancing), as well as the professionalization of medical education (The Josephinian Academy in Vienna - *Josephinum*) and administrative procedures (Lesky 1959: 1–228, Loetz 1993, Lohff 2019).

The eighteenth century marked the initial phase of the “paper technology” era. During this period, the state began systematically registering births and deaths, while hospitals recorded patient admissions and discharges. These records often included columns for names, ages, dates of admission or discharge, and sometimes additional data such as occupation (Kassell 2016: 120-135; Weisser 2024). In 2010, medical historians Volker Hess and J. Andrew Mendelsohn explored the connection between medical knowledge and paper technology. The authors highlighted the importance of “case and series”, emphasizing patient histories as crucial sources for generating medical knowledge. They argued that such records were prerequisites for constructing epistemically meaningful series in medical contexts. They stated (Hess, Mendelsohn 2010: 287-314):

“Questionnaires, hand-drawn columns or tables, or printed schemata: all such formatting, prescriptive in both the normative and literal sense, operates by fill-in-the-blank. Designed to ease the collection, organization, and storing of knowledge, prescriptive formatting also had unplanned effects, among them the production of series.”

The technology of paper prescribing originated in the early modern state administration in the form of simple lists used to manage data. Simple tables with rubrics became essential administrative tools across civil, military, and medical contexts (Rusnock 2002).

In military contexts, precise figures on prisoners of war, the wounded, or the dead enabled an “evaluation” of wars and informed strategies to enhance military and medical efficiency. Source materials from the Habsburg-Ottoman Wars of the eighteenth century reveal that such data were analyzed by authorities to address health-related issues, such as ensuring the availability of sufficient medical personnel, medication, food, clothing, and bandaging materials, or determining whether a temporary hospital needed to be established due to heavy losses.

In 1906, the physician Friedrich Prinzing wrote *Handbuch der Medizinischen Statistik*, which, in its second edition (Prinzing 1931), included historical statistics on mortality. According to Prinzing, famine and war were key factors contributing to increased mortality throughout history.

Furthermore, Prinzing outlined an approach that established him as a pioneer in the history of military medicine, namely, the study *Epidemics Resulting from Wars* in 1916 (Prinzing 1916). He adopted a statistical methodology, analyzing quantitative source material on the mortality of so-called “war epidemics”. Prinzing used this data-driven approach to highlight the high mortality rates associated with military conflicts. He emphasized the detrimental impact of the intersection between warfare and epidemics on the health of both civilian and military populations (Prinzing 1931: 640-650). The case presented in this paper will also be connected with warfare and its effects on the spread of pestilence in zones of conflict including its hinterland.

The highly diverse sources resulting from the manifold record-keeping procedures during epidemics provide historians with valuable insights into the nexus of health data and population dynamics. However, each data set allows us to gain in-depth understanding of single cases, which in turn enables us to gain a broad comparative perspective, useful in subsequent analyses of new datasets for the purpose of research on infection patterns, disease progression, and mortality in the early modern area.

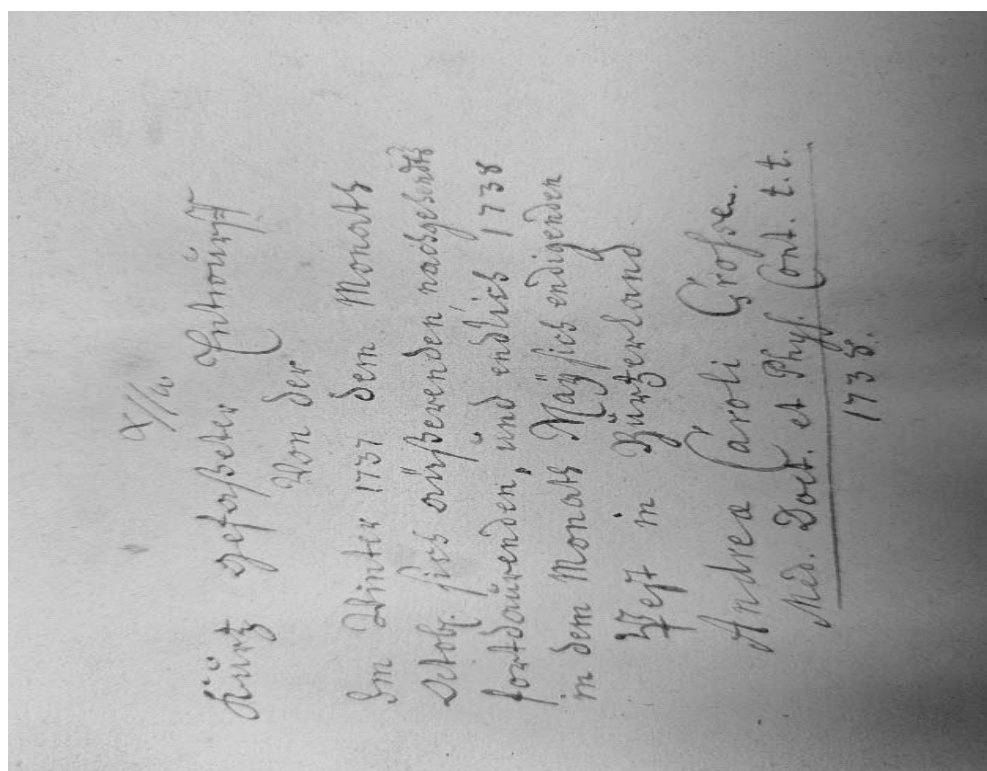
3. The reports of the physician Grosse on a plague outbreak in Transylvania (1737-1738)

In October 1737, shortly after the Habsburg army had launched a military campaign in the region, the plague spread from Wallachia to Transylvania. Local authorities, however, were uncertain whether the disease was the “real” bubonic plague or another illness. From Transylvania, the plague was transmitted to the Banat and Hungary by military forces, particularly the Grünne Regiment stationed in Sibiu (Sorescu-Iudean 2025a). At this time, the Habsburg-Ottoman War (1736-1739) had transformed the south-eastern margins of the Habsburg Empire into a war zone (Angeli 1881: 247-338, 409-479). With the transfer of the Grünne Regiment to the Banat, the epidemic intensified in the conflict-affected region, likely influencing the outcome of the war (Hammer 1839). This outbreak underscored the significance of locally based and organized sanitary commissions in Sibiu, Timișoara, and Osijek as local managing institutions of health. In our case, the correspondence of the commission in Sibiu provides valuable insights into the spread of the epidemic, contemporary perceptions of the disease, and the strategies implemented to contain it.

In Juli 1738 the report *Kurtz gefaßeter Entwurf von der Im Winter 1737 dem Monats Octobri sich äußerenden nachgehendts fortdaurenden, und endlich 1738 in dem Monath May sich endigenden Pest im Burtzerland was in Juli 1738* was submitted from

Sibiu to the Sanitary Court Commission in Vienna. The report dealt with the plague in the historical region Țara Bârsei (Burzenland) between October 1737 and May 1738. The document will be the key source for this article.

Figure 1. Cover sheet of Grosse's report



Source: OeStA [Austrian State Archives](c).

The author of the report was Andrea Caroli Grosse. Born in Cristian, a large village in Țara Bârsei near Sibiu, Grosse was the son of the local priest. He studied medicine in Halle from 1729 to 1732 and began his career as a military physician in Wallachia before being appointed as a doctor in Transylvania by the Viennese court. The limited available sources indicate that Grosse spent the majority of his life practicing medicine in Transylvania. According to parish registers, he passed away in 1757 in Sibiu (Trausch 1870: 38, Offner 2006: 299). In 1737 he was recorded as holding the position of *Pestchirurgi* (plague physician).

The inclusion of such early modern medical reports in our research allows us to put the spotlight on the contemporaneous perception of illness and health (Dinges et al. 2015, Steinke, Stuber 2004: 139-160, Fossel 1913: 238-252, Schlegelmilch 2015: 100-110, Stolberg 2023, 357-385). As Michael Stolberg has noted, these represent significant testimonials of practices of producing evidence for the production of medical knowledge. The medical historian defines further (Stolberg 2015: 78):

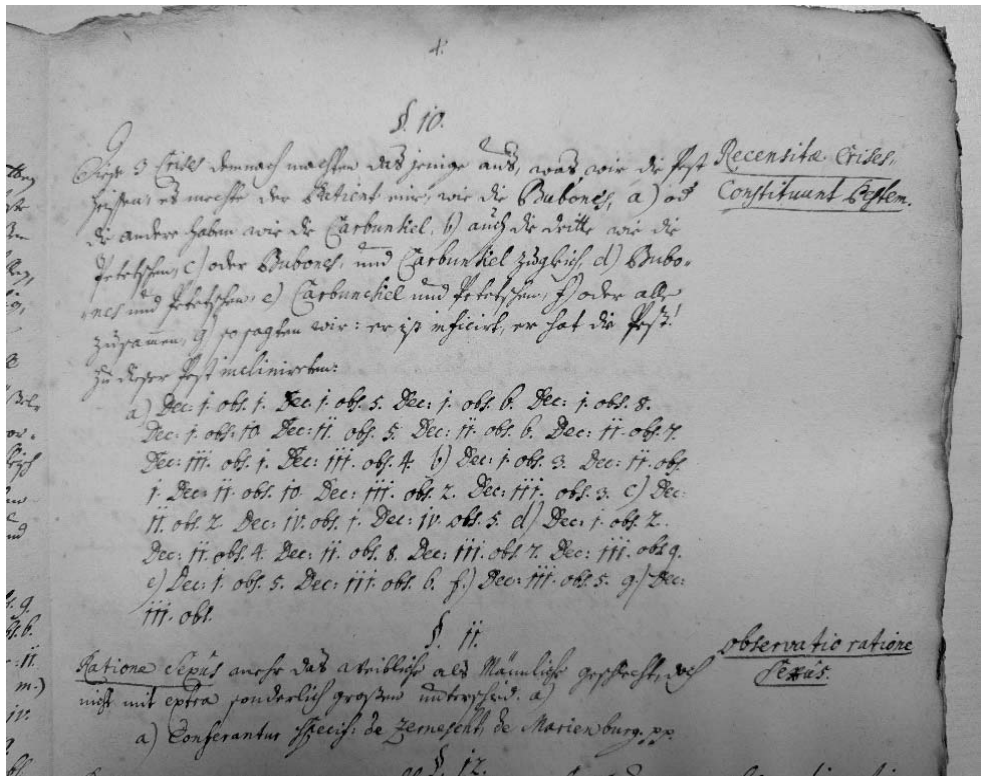
At its core lies the question of how scholars and scientists, at different times, arrive at specific insights and convictions—how they develop hypotheses and theories from a multitude of individual observations on humans, in nature, or in the laboratory, as well as from serial, experimentally generated data.

Stolberg refers to the duality of medical writings as either public or private records, to the growing interest among scholarship into communicative practices (among others diaries, letters, laboratory journals or official reports), and ascribes to them a key role in the implementation of new knowledge and practices (Stolberg 2015: 78-79).

In the accompanying letter of the report, Grosse emphasizes that he submitted the report on demand of the authorities and that the material concerning the plague in Țara Bârsei is based on facts only, „without the slightest enlargement or reduction of the incidents”.

The report itself is divided into three parts: A descriptive analyses of his results, an *observatium* based on individual patient cases, and a travel diary (*diarium*) from November 1737 until May 1738. All three parts refer to each other. His description of results in the first part are linked with the number of the *Observationes*, the patient case (for example see fig. 2: Dec(as) I obs. I). This approach allowed Grosse to prove his findings with facts based on his own set of *Observationes*, made during visitations. The physician was instructed by the local Commanding General of the province Field Marshal Johann Georg Christian von Lobkowitz (1686-1755) to visit infected or perhaps infected villages in order to medicate the infected population.

Figure 2. Observations as reference for a fact based analyse



Source: OeStA [Austrian State Archives](c).

The first part of the three is titled “Von der 1737 im Burtzerland an Siebenbürgen grassirenden Pest” and divided into 27 sections. Grosse located the origin of the plague in the Ottoman Empire (Panzac 1985). He referred to *Sistok* as possible place of origin, a place close to the Danube, where the plague had raged in May and June in 1737. For Grosse was clear that the plague had been transferred from Walachia to Transylvania and the Țara Bârsei by military troops. In a second step Grosse tried to trace “patient 0” of the Țara Bârsei. The physician explained that in October 1737 the plague broke out by a *Compagnie Marquetainer*, a merchant of the Damnitz Regiment in Codlea (Zeyden). Grosse stated that the deceased merchant and his wife transferred the disease to the local inn owner. At the same time Grosse traced the plague to the Wallachian village of Zărnești (Zernescht) in farmhouses, which had served as quarter for Wachtmeister von Gylani and his hussars. In October a

person from the village Toarcla (Tartlen) was dispatched to the imperial magazine in Braşov (Kronstadt). In Braşov he got a used tobacco pipe as present from a soldier and brought the plague back into the village. According to Grosse, the plague emerged from these three places. Outgoing from Coldea, Zărneşti and Toarcla the disease was then transferred to Vlădeni (Vladany), Vulcan (Volkendorf), Tohanu (Tohan), Apaţa (Apatza), Sânpetru (Petersberg), Feldioara (Marienburg) and Ghimbav (Veidenbach). These ten villages, ravaged by the disease, were the centre of attention in Grosse's report.

From the physician's perspective, disease transmission occurred through *Miasma Pestilentialia* via *Humoribus Corporis Humani*, as well as through sweat, saliva, or the exhalation of unhealthy air. Additionally, direct contact with buboes and carbuncles containing pus, as well as with fabrics that had come into contact with them, was considered to be highly risky. Grosse's theory of disease transmission reflects an interesting combination of contagion theory and miasma theory. He describes the symptoms of the disease, which include headache, nausea and vomiting, muscle aches, general weakness, fatigue, blackened skin (gangrene), sudden onset of high fever and chills, and swollen, painful lymph nodes (buboes) in the groin, armpits, or neck. He also provides an account of the progression of the disease, as the presence of buboes, carbuncles or petechiae, characterized as "crisis" indicate a plague infection, according to his concept.

According to Grosse's account, slightly more women than men died during the plague outbreak. A few of the women had been pregnant, showing buboes, but had had no abortive birth. Concerning the age of plague victims, according to Grosse's analyses, in every other village except Zărneşti more adults than children had passed away. Outgoing from humoral pathology Grosse wrote concerning *Ratione Temperamentorum* that only sanguine and phlegmatic persons were been infected by the plague, while the choleric and melancholic type had been spared.

Temporally, he identifies a peak in cases in October and around Christmas, while noting a decrease in lethality during the full moon. The physician likewise noted that during the plague outbreak, the incidence of other diseases, such as measles and smallpox, declined. In this context, it is important to acknowledge the evident effectiveness of quarantine as a medical technique for isolating infected individuals to prevent the spread of disease.

Grosse focused extensively on the issue of prevention. He identified three categories of preventive measures practiced in the Țara Bârsei. The *Ratione Prophylaxeos Theologica* encompassed two daily prayers, along with personal penitential prayers, seeking God's forgiveness for sins and requesting

divine intervention to restore the health of the infected. Grosse's concept of *Ratione Prophylaxeos Politica* was based on orders issued by the military leadership, the sanitary commission and the directives of the Braşov magistrate. However, he critically highlighted a significant issue: these measures were not implemented as intended. Healthy villages failed to properly restrict access to individuals from infected areas, roads were not adequately maintained, and dead cats and dogs were not buried as required. Additionally, sick cattle were improperly processed for consumption, public gatherings continued despite prohibitions, and individuals neglected to report cases of illness or adhere to quarantine regulations. Furthermore, people exchanged clothing and inherited belongings from deceased infected individuals, while officials failed to provide essential support, such as food and firewood, to affected households. This description reflects a reality in which official norms were not fully observed. Grosse introduced his final category, *Ratione Prophylaxeos Medico*, also with a critical remark: no one had consulted physicians on which preventive measures would be effective against plague infection. The idea of prevention had not yet arrived in the minds of the population. He emphasized the importance of mental stability in relation to his own role as a medical professional, which, in the early modern period, was closely associated with prayer. For their own protection, physicians followed a diet that included vinegar and they disinfected their mouths with wine or schnapps. Additionally, they chewed juniper, fumigated rooms after attending to patients, disinfected their own clothing, maintained distance from patients' breath and sweat, and took measures to protect their faces. Grosse determined that the prophylactic measures implemented by the government in Vienna and enforced by local medical personnel were not sufficiently observed by the population and certain officials, rendering the regulations ineffective. The preventive strategies employed were primarily based on the principles of separation and quarantine, which were considered the most essential tools for controlling the spread of infectious diseases until nowadays (Jesner 2021).

Figure 3. Diarium, Tabell I, January 12, 1738

Dörfer	Häuser	gestorbene	Kranke	Rekonvaleszente
Creyden	33	56	28	30
Wolkenborn	7	15	3	5
Reidenbach	5	13		9
Zernezsch	42	109		52
Johan	1	8		
Petersberg	1	4		2
Summa	89	215	31	98

Source: OeStA [Austrian State Archives](c).

Following his description of the medical treatment practices for the plague, including the *Cura Pestis* with its XXI sub-sections, Grosse presents a *General Tabell*. In his travel diary, the physician recorded statistical observations based on his visits to infected villages. In 1737, he documented and analysed the spread of the disease by categorizing data into villages (*Ort*), infected houses (*Häuser*), patients (*Kranke*), and deceased individuals (*Gestorbene*). By 1738, he began numbering his tables (Tab. I – Tabella XVIII) and expanded his analytical approach by incorporating additional categories, including villages (*Dörfer*), houses (*Häuser*), deceased individuals (*Gestorbene*), patients (*Kranke*), and convalescents (*Rekonvaleszente*).

These aggregated datasets enabled Grosse to conclude his report with a table (figure 4) that facilitates drawing conclusions about the mortality rate during the period under investigation.

Figure 4. General Tabell From October 1737 until May 1738

General Tabell.

Ort	Häuser	Personen
Terslan	1	5
Petersdorf	1	4
Seibersdorf	5	9
Tha.	1	8
Wickendorf	7	21
Oeden	24	60
Wadung	1	6
Kendell	4	11
St. Michael	5	11
Marienthal	2	4
10.	101	382

Summa: 101 Häuser, 382 Personen.

Source: OeStA [Austrian State Archives](c).

In ten villages, 101 houses were infected, with a total of 382 individuals affected, of whom 133 survived the disease. Gathering information through the use of such handwritten structured forms (Figure 3 and 4) allows us to trace first attempts of producing statistical knowledge in medical contexts.

4. Grosse’s Observations: Small steps toward an individual patient history

Finally, we turn to the field of patient history, which emerged as a distinct area of study within the history of medicine in the late twentieth and early twenty-first centuries. Traditionally, the history of medicine centred on prominent physicians, landmark discoveries, and institutional developments. However, from the 1970s onward, scholars increasingly sought to recover the experiences of patients, reflecting the rise of social history and a growing interest in marginalized voices (Gillis 2006: 490-512, Warner 1999: 101-111). This field intersects with the histories of the body, emotions, disability, and public health,

drawing on diverse sources such as patient letters, diaries, asylum records, oral histories, and series of cases like Grosse's *Observationes* (Vanja 2006: 26-35, Stolberg 2016: 499-518, Churchill 2012).

Grosse provides valuable insights into Transylvanian patient history in the 1730s. He documented 50 cases in the report, systematically indexed within five sections (Decas I–V). During his *Visitationen* (instructed journeys) in the ten villages to practice physical examination of potential infected and already sick persons, Grosse was accompanied by a *Contagions Chyrurgo*. By the eighteenth century, such visitations had become a common political instrument for monitoring and directing governmental (health) strategies in rural areas. While the origins of this practice can be traced to religious traditions, it evolved into a powerful administrative tool (Zeeden, Lang 1984, Näther 2014: 121-136, Kröll: 2024).

Grosse's journeys were clearly governmental missions, as evidenced by his frequent diary entries documenting his reports to the Sanitary Commission in Sibiu, Field Marshal Lobkowitz, General Field Marshal Wolf Siegmund von Damnitz, and the Braşov magistrate. His entries allow for the reconstruction of his travel route. The report presents 50 case studies, divided into 17 cases involving female patients and 23 involving male patients, of whom 22 were children. Grosse did not provide any explanation for this particular selection; however, he noted the existence of additional cases, some of which were similar to those presented in the report. Furthermore, he mentioned that he became ill in December, shortly before Christmas, and remained unwell until the first week of 1738—a circumstance that adversely affected the structuring of the selected sample, as he was unable to document cases accurately during that period.

Grosse was influenced by a Galenic medical milieu and was committed to providing detailed descriptions of symptoms and the progression of disease, with particular attention to the occurrence of a “crisis” as a pivotal turning point in contemporary perceptions of illness. Consequently, we will examine several cases. For example, he documented the illness of a seven-year-old boy who developed a bubo under the armpit that enlarged to the size of a hazelnut by the second day of observation, and who ultimately died on the third day without receiving any treatment. Another case highlights the dangerous misconduct of a Saxon plague physician. The physician used a piece of fabric to wipe the purulent buboes and carbuncle of a patient and subsequently repurposed the same fabric as socks in his shoes. He justified this action by citing the exceptionally cold weather and his fear of freezing to death. A woman from an infected household developed a pestilential fever, experiencing

alternating chills and hot flashes, as well as episodes of delirium, for nine days. Throughout this period, no clear turning point or “crisis” could be identified, although she did not suffer from severe pain. On the tenth day, Grosse decided to perform bloodletting, after which the patient's condition gradually improved. She regained coherence, her delirious episodes ceased, and she expressed a desire to eat. By the second day following the treatment, she had fully recovered and was considered convalescent. Grosse also documented the infection of a Wallachian pope in his forties. The initial symptoms included limb pain and hot flashes, followed by the development of two buboes in the groin area. One bubo was elongated and thick, resembling a sausage, while the other, located slightly below the first on the same leg, was approximately the size of a goose egg. These buboes were treated with specialized plasters; however, they only began to diminish in size after fourteen days and completely disappeared after four weeks.

The selected cases from Grosse's sample illustrate how the physician systematically summarized key information, including the patient's sex, age, symptoms, treatment, disease progression, and, in some instances, details regarding the chain of infection. Grosse did not anonymize his patients; however, his approach was not entirely consistent, as he occasionally provided the name of the patient or a close relative, such as a father. Individual observations conclude with a Scholion—a type of explanatory comment that highlights what made the case noteworthy or representative.

Grosse's diary provides limited insight into the physician-patient relationship; however, it does reveal that visits to sick individuals occurred on a regular basis. During his stays in villages, he oversaw the burning of material goods and maintained close contact with various locations classified as hazardous, necessitating his own periodic quarantine. His final diary entry, dated May 14, 1738, states: “In the afternoon, we finally arrived in Sibiu and successfully concluded this expedition.” At this point in time all villages were free from the disease.

5. Conclusion

This study demonstrates that early modern Transylvania, as exemplified by Andrea Carol Grosse's medical reporting during the plague outbreak (1737–1738), was a formative arena for the emergence of systematic health data reporting and recordkeeping. Grosse's detailed observations, structured data collection, and incorporation of patient histories highlight how early modern medical practitioners began to harness quantitative and qualitative data to understand and manage epidemics. His work provided immediate

administrative and clinical guidance during a critical public health crisis for the court in Vienna.

The analysis reveals that the Habsburg Monarchy's increasing reliance on data collection was deeply intertwined with its broader strategies of state centralization, military readiness, and economic management. Health, reinterpreted as a collective asset crucial to national strength, spurred innovations in administrative practices—including the creation of handwritten tables, patient case series, and early statistical compilations. Grosse's report, with its methodical indexing of cases and integration of narrative patient histories, exemplifies the nascent “paper technology” that facilitated the transformation of sporadic medical observations into structured epidemiological evidence.

Moreover, the paper illustrates the complex interplay between governmental directives, military movements, and local practices, emphasizing that effective public health measures depended not only on data collection but also on how faithfully measures were implemented. Grosse's critical commentary on the shortcomings of local quarantine and preventive practices underscores the challenges inherent in early modern public health governance. His dual approach—combining empirical data with contemporary medical theories such as miasma and contagion—prefigures later developments in evidence-based medicine and biomathematics.

In sum, this study contributes to our understanding of how early modern efforts in health data reporting and recordkeeping were instrumental in shaping public health policies and practices. It positions Grosse's work as a key transitional moment in the evolution from individualized case studies to systematic epidemiological analysis, thereby offering valuable insights into the origins of modern medical statistics and the enduring role of patient histories in generating medical knowledge.

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