Patient’s history questionaire

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Welcome to our practice,

we would like you to feel comfortable! By using this written questionaire we aim to avoid unwanted listening by other patients at the front desk. Please take your time to fill in the requestet information. If you have any question feel free or ask us.

Personal Data:
We need the following informations to set up your patient file and enable the billing process to your health care insurance

Health Care Insureance	
Type of insure	❍ Member ❍ Familiymember ❍ Retired
Surname/ Name	
Date of birth	
Street, Number	
Postal Code; Place of residence	
General Practitioner; Internal Med.	
Telefonnumber!	private: buisness : mobile: e-mail adress:

Data security and privacy:
In cases I won’t be able to take care of you personaly due to vaccations or illness, it might be necessary that one of my collegues hast o take care of you. For these occasions I ask for your consent to allow these collegues access your patient file

Date / Signature:____
By signing this I confirm the Correctniss oft he data given above and my consent

Reminder:

If you agree, we offer the service of reminding you of your next appointment

O Yes please; Date / Signature: ________________________________
O No thanks

Please turn!!

Post medical history?

This questions are not supposed to be a substitute for personal attention. It allows our team to prepare your appointment property.

Family status:

❍ single ❍ married ❍ divorced/ split ❍ widowed ❍ Long-term relationsship

Profession: ____

Parents:	Grandparents:	Sister / brother:
❍ Cancer (who/ Type)	❍ Cancer (who / Type)	❍ Cancer (who / Type)
❍ Diabetes	❍ Diabetes	❍ Diabetes
❍ Heart attack	❍ Heart attack	❍ Heart attack
❍ Lung Embolism	❍ Lung Embolism	❍ Lung Embolism
❍ Stroke	❍ Stroke	❍ Stroke
❍ Thrombosis	❍ Thrombosis	❍ Thrombosis
❍ high blood pressure	❍ high blood pressure	❍ high blood pressure

Your own history:

❍ Cancer (cancer type) ❍ high blood pressure
❍ Diabetes ❍ Heart attack
❍ Thrombosis ❍ others? _________
❍ Lung Embolism
❍ Stroke Allergies?______________

Own operations: _______________ Year ? ________

Date of last mammography? __________

Deliveries: ❍ none

1. Birth / Date:______ ❍spontaneous ❍vacuum extraction ❍cesarian section ❍breast feeding
2. Birth / Date:______ ❍ spontaneous ❍vacuum extraction ❍ceasarian section ❍breast feeding
3. Birth / Date:______ ❍ spontaneous ❍vacuum extraction ❍ceasarian section ❍breast feeding

First menstrual bleeding (menarche) at age:____ last menstrual bleeding (menopause) at age: ___

Last menstrual bleeding (first day) _________

Intervall between bleedings (first day of bleeding to the next first day of bleeding _________

Birth Controll? ____

Contraceptive pill; condoms, sterilisation

Medications on regular basis !____

❍ Cigarettes: if yes: how much ? ❍ alcohol?

Current complaints: ____

Or other reasons for appointment (e. g. cancer check up)

height: weight: last vaccination of tetanus/ diphtheria:

rubella vaccination:

HPV vaccination:

Thank you for your cooperation your practice team Schweigart / Gerling / Dr. med. Dewes / Dr. med. Wille