Ärztehaus Mitte

medical history

Dear patient!

In order to provide you with the best possible care, we ask you to fill out the following questions.

surname, first name: .....

date of birth: .....

profession: .....

phone : ..... mobile: .....

e-Mail: .....

Did you have or do you have any of the following diseases? Since when? Please provide details:

high blood pressure	no □ yes □ .....
heart attack, circulatory trouble	no □ yes □ .....
heart diseases	no □ yes □ .....
stroke	no □ yes □ .....
circulatory disorders of the legs	no □ yes □ .....
diabetes	no □ yes □ .....
lipometaloic disorders	no □ yes □ .....
tumors	no □ yes □ .....
liver diseases	no □ yes □ .....
chronic infections	no □ yes □ .....
bleeding disorders / blood disorders	no □ yes □ .....
pulmonary diseases (asthma, COPD)	no □ yes □ .....
thrombosis or pulmonary embolism	no □ yes □ .....
eye diseases	no □ yes □ .....
mental illness	no □ yes □ .....
convulsions/neurological diseases	no □ yes □ .....
Operations/accidents	no □ yes □ .....
Others	no □ yes □ .....

Do you smoke? If yes, how much: ..... no longer since: .....

Do you drink alcohol on a regular basis? If yes, how much? .....

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Do you have allergies? no □ yes □

Against medicines? no □ yes □

- If yes, against which medicines?.....

- Other allergies:.....

How tall are you: .....cm What´s your weight: .....

Have you put on or lost significant weight in the last 6 months? no□ yes□

Which medicines do you take regularly?

.....

.....

Please bring you vaccination certificate with you to the next examination.

Is there any other information that you may want to provide here?

.....

Letter of acceptance

Please always arrange an appointment!

If you are unable to keep your appointment, please notify us at least 24 hours in advance.
In case of repeated non-appearance without cancellation we reserve the right to charge you the fee for the services booked for your appointment.

I agree with the above regulation.

I hereby consent to the processing of my personal data by the doctor´s office. I have been advised that I can revoke this consent at any time in writing or by e-mail to the doctor´s office (Art.7 Abs. 3 GDPR). I am aware that my revocation of consent, which I can at any time, does not affect the legality of the processing carried out on the basis of the consent up to the time of revocation (Art. 7 Abs. 3 Clause 2 GDPR). I am aware that my data will be treated with strict confidentiality and, if necessary, saved electronically. They are subject to medical confidentiality in accordance with Section § 203 StGB and the strict data protection provisions. I have given all information to the best of my knowledge and belief.

Thank you

Your Team Ärztehaus Mitte

.....
Date/ Signature