ALLGEMEIN MEDIZIN DUS

ANAMNESIS, MEDICAL HISTORY

Surname, Given name _____

Address

Telephone Mobile

Profession _____ Date of birth _____

Email adress _____

Height _____ cm

Weight kg

Regular sport activities? ☐ no ☐ yes _____ times per week

Do you smoke? ☐ no ☐ yes cigarettes per day

How much alcohol do you consume per day?

Do you have any allergies? ☐ no ☐ yes

If yes, which ones? _____

Do you take any regular medication?
☐ no ☐ yes

If yes, which ones? _____

Are your vaccinations current?

Tetanus	no	yes	Hepatitis	no	yes
Diphtheria	no	yes	Influenza	no	yes
Polio (Poliomyelitis)	no	yes	Pneumonia	no	yes
Pertussis (Whooping Cough)	no	yes	Mumps-measles-rubella	no	yes

Do you wish to be informed about necessary examinations or vaccinations? ☐ no ☐ yes

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Are any of the following diseases known in your family (parents, siblings, uncle, aunt)?

Heart disease/Heart attack	yes	from whom?
Diabetes	yes	from whom?
Stroke	yes	from whom?
Cancer	yes	from whom?
		which?

Do you suffer from any of the following diseases? ☐ **none**

High cholesterol	yes	High blood pressure	yes
Epilepsy or seizures	yes	Heart disease	yes
Diabetes	yes	Thyroid disease	yes
Bleeding Disorder	yes	Liver disease	yes
Stomach disease	yes	Intestinal disorder	yes
Kidney disease	yes	Rheumatism	yes
Chronic Bronchitis/Asthma	yes	Allergies	yes
Stroke	yes	Cancer (specify type)	yes

Others: _____

Have you had any surgeries? ☐ **none**

Heart	yes	Breast/chest	yes
Vascular	yes	Uterus	yes
Cancer	yes	Tonsils	yes
Thyroid	yes	Appendix	yes
Gallbladder removal	yes	Hernia	yes

Others: _____

Dear patients, how did you find our medical practice?

☐ Recommendation ☐ Telephon book ☐ Newspaper ☐ Internet ☐ By chance

Thank you for taking the time to answer the questions!

I consent to my treatment data being processed and stored by the medical practice in accordance with the 'Consent Form for the Collection of Patient Data'. I understand that I may withdraw this consent at any time, in whole or in part, with future effect. Data shared under this consent remains lawful. This consent is voluntary, and treatment will not be denied if I choose not to consent.

Place and date **Signature**