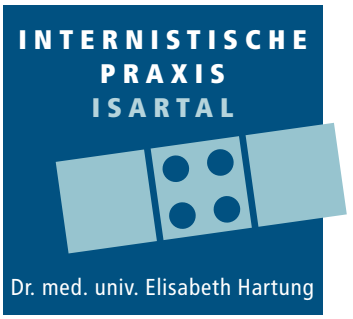
MEDICAL HISTORY QUESTIONNAIRE



Internistische Praxis Isartal
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Consultation hours
Monday
07.30 a.m. - 01.00 p.m.
Tuesday
08.00 a.m. - 01.00 p.m.
Wednesday
02.00 p.m. - 06.00 p.m.
Thursday
08.00 a.m. - 01.00 p.m.
Friday
07.30 a.m. - 01.00 p.m.

Dear Patient,

Welcome to my medical practice. The following information is very important for your treatment. Please fill in the necessary information prior to your consultation. Should any of the questions be unclear, I am happy to help you. All of your answers are treated completely confidentially as medical information and strict medical secrecy is respected. Please sign at the end of the document to confirm that your answers are complete and correct.

Thank you very much!

Surname

First Name

Date of Birth

Adress

Telephone number

Email

Occupation

Health insurance (company? location? policy number?)

Height in cm, weight in kg (or select unit of measure?)

Do you have children?

For women: Are you (or could you be?) pregnant? Yes ☐ No ☐

Please state the number of births/ number of pregnancies

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INTERNISTISCHE PRAXIS ISARTAL

Dr. med. univ. Elisabeth Hartung

Do you have any known allergies?

☐ No ☐ Yes, which ones?

Do you have an allergy passport? ☐ No ☐ Yes

Do you smoke?

☐ No

☐ I have quit smoking since Years Months Number of cigarettes per day

☐ Cigarettes ☐ Cigarillos ☐ Cigars ☐ Water pipe ☐ Pipe ☐ E-Cigarettes

Do you take any potentially addicting substances?
(Anabolics, Stimulants, Sleeping meds or other drugs)

☐ No

☐ Yes - which ones?

Do you take any medication(s) regularly?

☐ No

☐ Yes - which ones?

Have you had any childhood illness?

☐ No

☐ Yes - which ones? ☐ Measles ☐ Mumps ☐ German Measles ☐ Chicken pox

Other

What is your vaccination status? Do you need any booster vaccinations at present?

☐ No

☐ Yes - Please bring your vaccination record to your next appointment

Do you have any chronic illness(es)?

☐ No

☐ Hypertension
☐ Diabetes mellitus
☐ Coronary heart disease
☐ High cholesterol
☐ Depression
☐ Kidney disease
☐ Asthma
☐ Chronic bronchitis
☐ Epilepsy
☐ Gastritis
☐ Liver disease
☐ Infection

Other

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Have you ever had a heart attack, stroke or thrombosis?

☐ No

☐ Yes - What? When?

Which therapy /rehab treatment was given?

Do you still suffer from any limitations or remaining symptoms?

Have you ever had an operation?

☐ No

☐ Yes - When, for what reason?

When? Where? (Hospital)

Have you ever been diagnosed with cancer?

☐ No

☐ Yes - Which type?

Which treatment was given?

Could the illness be cured ☐ Yes ☐ No

Is there any history of serious medical conditions in your family (parents, siblings, grandparents, aunts or uncles)?

☐ No

☐ Yes - which ones? For example:

☐ Heart-circulatory illness

☐ Thrombosis / Lung embolism

☐ Cancer

☐ Dementia

If over 35 years old, have you ever had a health check-up (medical screening) specific for your age group?

☐ No

☐ Yes - when was the last check-up done?

Where there any abnormalities found?

Ebenhausen, (date)

Signature of patient or legal guardian

How did you get to know my practice?

☐ Internet

☐ Recommendation

☐ Phone book

☐ A relative is already a patient

☐ Others

May I inform you in respect of your next Check-up and your next vaccination?

☐ Yes

☐ No

☐ e-mail

☐ mail