Patient questionnaire

Dear patient,

Please show all your available medical reports to our employees.

→ hospital reports
→ medical reports
→ radiology reports (MRT, CT)
→ medication plan!

Without knowing your reports, helpful treatment is often not possible!

Last name: _____ First name: _____

Date of birth: _____Occupation: _____

Phone number: _____Mobil: _____

E-mail: _____ Weight: _____ Hight: _____

please check where applicable!

	yes	no	quantity per day/week
nicotine (cigarettes)			
alcohol			
	----	----	in your family
high blood pressure			
high cholesterol			
tumor disceases			
diabetes mellitus			
stroke/ apoplexy			
peripheral artery disease			
epilepsy			
asthma			
coagulation disorder			
infectious diseases (HIV? Hep.?)			
heart disease? (e.g.: cardiac arrhythmias, heart attack,…)			
mental illness? (e.g.: depressions)			
allergies (also on medication):			
surgery in the last years?			

please turn around →

please describe your current problems as precisely as possible.

(must be filled in!):

_____

_____

_____

_____

_____

_____

current medication (medication plan):

_____

_____

my family doctor is (with complete address):

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privacy

I agree, that my data can be exposed to all employees if necessary.

I have been advised that all employees are obliged to maintain discretion.

My data can ba submitted to third party affiliates e.g. local doctor, health insurance company via e-mail if required.

This permission can be withdrawn at any time.

I agree, that informations can be given to the following relatives, after their identity has been verified.

name: _____

name: _____

Frankfurt, ……..... .....
(Date) (Patient's signature)