HAUSÄRZTE
OBERKASSEL

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

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**