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Medical History Questionnaire

Dear patient,
in order to provide you with the best possible service, please complete the following questionnaire

Surname: _____ First Name: _____

Date of birth: _____ Place of birth: _____

Home address: _____ _____ _____
street zip code residence

Telephone mobile: _____ fixed-line: _____

Email-address: _____

Name of health insurance: _____

Do you have chronic diseases? _____

Do you take any regular medication? _____
(name/ dose)

_____

Allergies/ Medication allergies? _____

Do you have a care level rating? No ( ) Yes, I have care level 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 ( )

Are your **vaccinations** up-to-date? yes ( ) no ( ) ***please present this in our praxis***

Your height (m): _____ Your weight (kg): _____

Your emergency contact _____
(must be filled out) (name/ telephone)

I consent to the storage of the provided data and the transmission of the test results to my treating physician.

Date: _____ Signature: _____