HAUSARZTPRAXIS
SCHMIDT UND BOROWSKI

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**