Allgemeinarztpraxis
Theißen

Dear Patient,

We look forward to welcoming you as a new patient in our practice. In order for us to be able to adapt to your patient needs as quickly as possible, we need information in advance about your medical history and questions about how to handle your patient documentation.

Therefore, take the time to answer the following questions as completely and carefully as possible.
If you have any questions, our team will be happy to help and advise you.

General information Phone Email:

Name: Forename:

Date of birth: Age in years:

Sex: female ☐

male ☐

miscellaneous ☐

Size in cm: Severe disability: ☐ no ☐ yes Gdb:

Weight in kg: Long term care level: ☐ no ☐ yes: PG:_____

Social information

Occupation:

Family status: single ☐

married/in partnership9 ☐

Be Done/Notify Law ☐

Children: ☐ yes If so, how many:

☐ no

Smoke: ☐ yes if yes: 1) How many cig/day):

☐ no 2) How many years:

Alcohol consumption: ☐ No ☐ Yes ☐ if so how often/week and what:

Medical history

Allergies:

Pre-existing conditions: high		What, since when:	Treating specialist:
blood pressure	☐		
Diabetes mellitus	☐		
Heart disease	☐		
Asthma bronchiale	☐		
COPD	☐		
Gout	☐		
Elevated blood fat levels	☐		
Rheumatism	☐		
Cancer	☐		
Gastrointestinal disease	☐		
Abdominal disease	☐		
Thyroid disease	☐		
Skin disease	☐		
Ear, nose and throat	☐		
Eye disease	☐		
Joints and bones	☐		
Other	☐		

Operations and interventions:	Which one:	when:

Rehabilitation stays:	Which one:	when:

Are you enrolled in a so-called DMP?

☐ no

☐ yes if so, in which one:

Family history

Allergies: who:_____ what:_____

Pre-existing conditions: who: what:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Updates

Current complaints: Since when: what:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Take medication regularly: ☐ no ☐ yes

If so:

Medication plan available: ☐ yes: bi(e)

☐ no: bi(e) medications:

_____

_____

Authorization

The following persons are allowed to submit documents about my medical care (including prescriptions, referrals, admissions, ambulance tickets, copies of my documents) on behalf of my stead (upon presentation of their proof of identity)

☐ collect ☐ Request and order

Name	Date of birth	Address
_____	_____	_____
_____	_____	_____

I am aware that this power of attorney does not constitute a complete release from confidentiality by my family doctor towards the named persons and that information about my state of health or other information subject to confidentiality is not included in this authorization.

_____ _____

Location, Date Signed