Anamnesis

Dear Patient,

we are very happy to welcome you to our practice!
In order to offer you the best possible support and advice, it is important that we have, as far as possible, the most complete knowledge of your medical history. We have created this questionnaire to help you concentrate on and provide us with this information. Please answer the following questions as best you can.

Name: _____

E-Mail: _____ Tel. No: _____ Fax: _____

Occupation, children, marital status: _____

	Your own medical history	Your family's medical history
High blood pressure	○	○
Diabetes	○	○
Lipid (fats) metabolic disorder	○	○
Heart attack/Circulatory disorders of the heart	○	○
Stroke/Impaired blood circulation in the brain	○	○
Circulatory disorders of the legs	○	○
Kidney disease	○	○
Lung disease	○	○
Thyroid disorders	○	○
Psychological disorders	○	○
Thrombosis/Embolism	○	○
Glaucoma (increased pressure in the eye)	○	○
Cancer | If yes, which kind:	○	○
Allergies, skin disorders | If yes, which:	○	○
Operations | If yes, which:		
Other illnesses:		

Medication – which you are taking in addition to the medication already known to us (also non-prescription (over-the-counter) medication) If yes, which: _____

Smoking: ☐ occasionally ☐ daily ☐ non-smoker **Alcohol:** ☐ occasionally ☐ daily ☐ never

Weight: _____ kg **Height:** _____ cm **Care category:** _____ **Degree of disablement:** _____

Reduction in earning capacity: ☐ yes ☐ no

I hereby consent to being contacted for follow-up appointments for preventative health checkups, vaccinations and any intended medical checkups.

Date _____ Signature _____