Gemeinschaftspraxis Dres. Haversath

Before we take time to talk to you in person about your individual wishes and requirements, we also need, in addition to your personal details, information about your general state of health (medical history). Please fill out.

_____

surname, first name **date of birth** **phone number**

_____ _____

address (street name, place) **email** (important for digital applications)

height _____ cm weight _____ kg

allergies(f.e. medication) ☐ no ☐ yes, the following_____

smoker? ☐ no ☐ yes, pieces a day_____

alcohol? ☐ no ☐ yes ☐ rare ☐ regularly ☐ everyday

pregnant? ☐ no ☐ yes, in the ____. week

Do you have or had any of the following diseases?

☐ high blood pressure ☐ diabetes ☐ heart attack ☐ stroke

☐ thrombosis ☐ pulmonary disease ☐ tumor, cancer ☐ thyroid disease

☐ lipid metabolism ☐ other: _____

Operations / radiation therapy in the past?

☐ no ☐ yes, the following: _____

_____

Diseases that run in the family (parents, siblings)?

☐ high blood pressure ☐ diabetes ☐ heart attack ☐ stroke

☐ Thrombose ☐ pulmonary disease ☐ tumor, cancer ☐ thyroid disease

☐ lipid metabolism ☐ other: _____

Are you taking regularly medicaments?

☐ no ☐ yes, the following _____

_____

marital status _____ children _____ job _____

employer _____

I hereby confirm the accuracy and completeness of my information.

Date _____ Signature _____

Gemeinschaftspraxis Dres. Haversath

Declaration of consent by the patient to the transmission of treatment data and findings - Section 73 Paragraph 1 b SGB V

……..
Surname, first name

……..
Date of birth

……...
Health insurance

✓ I agree that my treating family doctor will receive treatment data and I obtain findings from, for example, a specialist or a psychotherapist or another service provider with whom I am receiving treatment. The persons concerned are obliged to provide this information for documentation purposes only to use further treatment. That I can give this consent at any time I am aware that you can revoke this in whole or in part.

✓ I agree that my treating doctor/psychotherapist may obtain the data and findings necessary for my treatment from my family doctor and other service providers with whom I am receiving treatment. The persons concerned are obliged to pass on this information. My treating doctor/psychotherapist may only use this information for the purposes of the services he is required to provide. I am aware that I can revoke this declaration of consent in writing at any time, in whole or in part.

✓ I agree to be contacted by telephone or electronically (e.g. to report findings). I am aware that I can revoke this declaration of consent in writing at any time, in whole or in part.

✓ I agree that findings and prescriptions can be picked up by third parties (relatives, nursing services, pharmacies, etc.). I am aware that I can revoke this declaration of consent in writing at any time, in whole or in part.

…… ……
Place Date

……... ……
Signature of the patient or signature of the legal representative

Signature of the doctor