Admission form

Dear patient,

Welcome to our practice. Please fill out the admission form at your first appointment so that we can get to know you better. Thank you very much!

Name /First name: .... Date of birth: ....

Adress:

Street: .... house number: ....

Post code, place: ....

Telephone: .... Mobil: ....

E-Mail: ....

Profession: ....

Previous general practitioner/family doctor
(Adress, Telephone): ....

Gynaecologist, Surgeon
(Adress, Telephone): ....

How did you hear about our practice? (Please mark with a cross where applicable)

- ☐ Homepage
- ☐ Google
- ☐ Other portals/websites
- ☐ Doctolib
- ☐ Instagram
- ☐ Others

☐ Recommendation by: ....

ANAMNES

Current complaints

………

………

Do you take medication regularly? ☐ Yes ☐ No

Yes, which one?

………

………

Do you take Blood thinners? ☐ Yes ☐ No

(Cumarine, ASS, Falithrom, Plavix, Clopidogrel etc.)

………

Do you smoke? ☐ Yes ☐ No

If yes, how much per day?

………

Do you drink alcohol on a regular basis? ☐ Yes ☐ No

………

Could you be pregnant? ☐ Yes ☐ No

………

Have you ever had an operation? ☐ Yes ☐ No

If yes, when and what kind of?

………

………

Allergies or intolerances: ☐ Yes ☐ No

If yes, which ones?

………

………

ANAMNES

Pre-existing conditions (please tick and complete if necessary):

Diseases of the heart/circulatory system:	☐ Yes	☐ No
Clotting disorder:	☐ Yes	☐ No
High blood pressure:	☐ Yes	☐ No
Mood disorder/depression:	☐ Yes	☐ No
Diabetes mellitus/metabolic disorders:	☐ Yes	☐ No
Tumour diseases:	☐ Yes	☐ No
Breast cancer in the family:	☐ Yes	☐ No
Last senological (breast cancer) screening examination:	☐ Yes	☐ No
Kidney diseases:	☐ Yes	☐ No
Nerve or muscle disorders:	☐ Yes	☐ No
Thyroid disease:	☐ Yes	☐ No
Asthma/Chronic Bronchitis:	☐ Yes	☐ No
Seizure disorder:	☐ Yes	☐ No
Chronic infectious diseases (hepatitis, HIV etc.):	☐ Yes	☐ No

Other diseases:

....

....

Place, date

Signature patient

Consent

Name /First name: .... Date of birth: ....

Declaration of consent Contact by the medical practice

☐ I agree that I may be contacted by the medical practice by telephone, mobile phone or email to be informed about appointment changes and appointment reminders.

☐ I would like to be informed about special offers.

I hereby agree that pictures may be taken in the course of my counselling and treatment to support and document the results.
I am informed that my pictures will be used exclusively for this purpose.
I am informed that I can revoke my declaration of consent at any time.

Declaration of consent Example images

My images may be used anonymously for example photos. These photos will only be stored in our internal practice programme. Such sample images can help patients to better inform themselves about an upcoming procedure/treatment and its outcome. All inferences of personal identity will be removed from the images.
I am informed that I can revoke my declaration of consent at any time.

☐ I consent to my images being used.
☐ I refuse the use of my images.

Declaration of consent data protection

☐ I agree that the practice may use the personal data collected here. data collected here - such as name, address, telephone number, e-mail address, medical data, treating doctors, doctors, photo documentation, etc. - and that this information may be used for medical purposes of medical treatment.

☐ I have taken note that the practice is in compliance with the regulations of the EU Data Protection Regulation (DSGVO), the Federal Data Protection Act (BDSG) and the Telemedia Act (TMG).

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Place, date Signature patient