

name

first name

birthday

phone

email



Dear patient

Thank you for choosing our practice.

To be able to give you optimal care we would like to ask you to give us some information about your previous medical history and life circumstances.

If there are questions you can't answer just leave it open.

Of course all information given will be treated confidentially.

Dr. Göser will personally go through the questionnaire with you afterwards.

Do you regularly take any medication? If so what and how much?

Are you allergic against any drugs or other substances? If so please name them.

Have you ever been seriously ill, been treated in hospital or do you suffer from any chronic illnesses?

Does anybody in your family suffer from high blood pressure, diabetes, heart conditions? Has anybody had a stroke, a heart attack, cancer?

please turn over---->

Do you smoke? How many cigarettes per day since when?

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Do you drink alcohol? If yes, how much in an average week?

Do you practice any sports? Do you have regular exercise?

What is or was your profession? What is your current occupation?

Do you live alone or with somebody else? Whom should we contact in case of an emergency?

Thank you for your help!

Is there anything you would like to add which we haven't asked about?

Should you wish to be informed about necessary future immunisations or other follow up examinations we would need you to give us written consent here. The recalls will be individually decided upon by Dr. Göser.

Date, place

name

signature

If you wish us to get reports from other colleagues or hospitals we would also need your consent here.

Date, place

name

signature