MEDI-INTEGRALIS
IHRE HAUSÄRZTE IN MITTE

Medical history form for new patients

Dear patient!
We look forward to welcoming you to our medical practice. For optimal support and advice, we ask you to fill out this questionnaire. The information will be attached to your patient file and is covered by medical confidentiality.

Personal Information

Surname, first Name:
Date of birth:
Phone number:
E-mail:
Adress:
Height:
Weight:

Pre-Existing Conditions

	yes	no		yes	no
Hypertension	☐	☐	neurological		
Diabetes	☐	☐	Disease	☐	☐
Lipid metabolism disorder	☐	☐	Mental Illness	☐	☐
Heart Disease	☐	☐	Accidents/Surgery	☐	☐
Stroke	☐	☐	Ear,Nose,Throat Disease	☐	☐
Liver Diseases	☐	☐	Infectious Diseases	☐	☐
Lung Disease	☐	☐	Skin Diseases	☐	☐
Thyroid Disease	☐	☐	Bone/Joint/	☐	☐
Gastrointestinal Disease	☐	☐	Disease		
Tumor/Cancer	☐	☐	kidneys/urinary tract/		
Vascular Disease	☐	☐	sexual organs		
Eye Disease	☐	☐	Disease	☐	☐
			Sleep disorder	☐	☐

Other diseases/conditions/accidents/operations not listed:
Allergies & Intolerances:
Strong increases/decreases of weight in the last 6 months:

Stimulants& Addictive substances

Nicotine frequency & quantity:
Alcohol frequency & quantity:
other Drugs:

Diet Habits

	yes	no
Mixed Diet	☐	☐
Vegetarian	☐	☐
Vegan	☐	☐
Other	☐	☐

For women

	yes	no
Is there a pregnancy:	☐	☐

Which week of pregnancy:
Complications:

Completed examinations

	yes	no
Gastroscopy	☐	☐
Colonoscopy	☐	☐
Cardiac Catheter	☐	☐

Participation in the Disease Management Program (DMP)

	ja	nein
Diabetes	☐	☐
Coronary Heart Disease	☐	☐
Asthma	☐	☐
Chronic Obstructive Pulmonary Disease	☐	☐

General Questions

Last check-up:
Last Skin cancer Screening:
Preventative care with a Gynecologist/Urologist:
Last Eye check:
Last Resting ECG:
Last Stress ECG:
Last 24 hour ECG:
Last long-term blood pressure measurement:

Full vaccination status:
Open vaccinations (can be checked by us):

Other Information

	yes	no
Pacemaker	☐	☐
Hearing Aid	☐	☐
Visual Aid	☐	☐
Walking Aid	☐	☐
Prostheses	☐	☐
Dental prosthesis	☐	☐
Stoma	☐	☐
Port	☐	☐
Shunt	☐	☐

other:

Social History

Current employment	☐	_____
Pensioner	☐	_____
Level of care	☐	_____
Degree of Disability	☐	_____

Family History

Diseases parents, grandparents, etc.
Family situation living situation, marital status:
Living will/Power of Attorney

Medication

Medication	Medication intake	For what?

Are you taking anticoagulant (blood-thinning) medication?

_____

Previous general practitioner or other treating specialists

_____

_____

_____

_____

Please bring your insurance card, your vaccination certificate, existing findings/doctor's reports and, if necessary, a medication plan with you to your appointment!

I confirm the information I have provided!

Place, Date **Signature**

_____ _____