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Medical History Form

To ensure the best possible care, please complete this form as fully as possible.
All Information is strictly confidential.

Personal Information

□ Male □ Female □ Diverse/Other

Last name:_____

First name: _____

Date of birth: _____

Occupation: _____

Phone: _____ Mobile: _____

E-mail : _____

Height:_____m Weight:_____Kg

Weight change in the past year: Yes □ No □

> 5 Kg change Yes □ No □

Living situation: alone□ With Partner□ With Family□ Nursing home□ Other: _____

Allergy

Allergy to medication: Yes □ No □

If Yes, which?: _____

Allergy card available: Yes □ No □

Type of allergic reaction?

Shortness of breath: Yes □ No □

Skin rash: Yes □ No □

Anaphylactic shock: Yes □ No □

Emergency Pen available: Yes □ No □

Other Allergies:_____

Family history

Has any close relative had a heart attack, stroke or cancer before the age of 50?:

Who and what?: _____

Substance use

Smoking: Yes □ No □

If Yes, how much?: _____

Since when?: _____

Alcohol: Yes □ No □

If Yes, how much?: _____

What kind?: _____

Since when?: _____

Drugs: Yes □ No □

If Yes, how much?: _____

What kind?: _____

Since when?: _____

Infectious Diseases

Known Infections: _____

HIV Yes □ No □

Hepatitis Yes □ No □

Germs (MRSA, ESBL, others) Yes □ No □

If Yes, what kind?: _____

Treating specialists

Diabetologist □ _____ Gynecologist □ _____

Vascular sugeon □ _____ Orthopedic specialist □ _____

Pulmonologist □ _____ Sugeon □ _____

Rheumatologist □ _____ Neurologist □ _____

ENT specialist □ _____ Urologist □ _____

Gastroenterologist □ _____ Oncologist □ _____

Dermatologist □ _____ Cardiologist □ _____

Others: _____

Medical History

		Since when?	Notes
High blood pressure	Yes □ No □		
Coronary heart diesease	Yes □ No □		
Stents	Yes □ No □		
Bypass	Yes □ No □		
Heart attack	Yes □ No □		
Heart rythm disorder	Yes □ No □		

Nordsternpraxis

		Since when?	Notes
Stroke/ vascular stenosis	Yes □ No □		
heart defect/ valve disease	Yes □ No □		
surgery	Yes □ No □		which Valve:
High cholesterol	Yes □ No □		
Kidney disease	Yes □ No □		
Diabetes	Yes □ No □		Therapy:
Cancer	Yes □ No □		
Pulmonary embolism	Yes □ No □		
Thrombosis	Yes □ No □		
Thyroid disease	Yes □ No □		
Rheumatism	Yes □ No □		
Autoimmun disease	Yes □ No □		
Orthopedic disease	Yes □ No □		
Neurological disease (MS, Parkinsons, Epilepsy, others)	Yes □ No □		which:
Clotting disease	Yes □ No □		
Blood thinning therapy	Yes □ No □		Drug:
Pacemaker/ ICD	Yes □ No □		type/last check:
Vascular disease (legs, Aorta, others)	Yes □ No □		
Asthma	Yes □ No □		
COPD	Yes □ No □		
Liver disease	Yes □ No □		
Mental health disorders	Yes □ No □		which:
Sleep disorders			
difficulty falling asleep	Yes □ No □		
difficullty stayin asleep	Yes □ No □		
Others	Yes □ No □		
Inflammatory bowel disease	Yes □ No □		

Documents

Advance healthcare directive Yes □ No □

Power of attourney Yes □ No □

Legal guardian appointed Yes □ No □

If Yes, Who?: _____

Reconized care level? Yes □ No □

If Yes, which level?: _____

Medication

Please list all medications (incl. over-the-counter, Vitamins, herbal products):

Name	Dosage	Frequency	For which conditions?	Since when

□ I do not take any regular medications