Questionnaire for patients	medipraxis Hausarztpraxis Dr. med. W. Mertz

Name, first name, birthday:	Today´s date:	
Telephone number:	E-Mail address:	
Profession / current activity:	Marital status:	Child, year of birth:
Size:	Weight:	
How did you hear about us?	Name/adress of previous GP:	

Current complaints / reason for consultation (put a cross in the box)

Fever:			
☐	Yes, how much?	☐	No
Pain:			
☐	Head	☐	Throat
☐	Neck, back (cervical/thoracic/lumba)	☐	Chest
☐	Abdomen / lower abdomen	☐	Joints
Airways:			
☐	Sniff	☐	Shortness of breath
☐	Cough	☐	Sputum(tenacious/yellowish/greenish/brownish)
Gastrointestinal:			
☐	Nausea / vomiting	☐	Pain in bowel movements
☐	Diarrhoea	☐	Blood in the stool
☐	Constipation	☐	Mucus in the stool
Urinary tract / genitals:			
☐	Painful urination	☐	Discharge
☐	Burning during urination	☐	Erection problems
☐	Blood in urine	☐	Flank pain
Eyes:			
☐	Visual disturbances	☐	Dry eye
☐	Red eye	☐	Foreign body feeling
Ears:			
☐	Hearing disorder	☐	Tinnitus / ear noises
Injuries / wounds:			
☐	Head	☐	Upper extremities (shoulder/arm/hand)
☐	Upper Body	☐	Lower extremities (knee/foot/ankle joint)
Paralysis:			
☐	Numbness	☐	Restrictions movement
Skin / allergies:			
☐	Rash, where?	☐	Itch
Weight:			
☐	Reduction	☐	Increase
Psyche:			
☐	Tiredness / sleep disorder	☐	Depression / memory impairment

Own previous illnesses: Yes or no (put a cross in the box)

Do you have a doctor or hospital records? Please hand in at the registration desk!

	Yes	No
High blood pressure		
Heart failure		
Heart attack		
Diabetes		
Stroke		
Dementia		
Depression		
Anxiety disorder		
Psychosis		
Other mental disorder (PTSD etc.)		
Chronic lung diseas (Asthma, COPD)		
Inflammatory rheumatism		
Gastrointestinal illnesses		
Liver disease		
Kidney disease		
Arthrosis (joints)		
Urinary tract disease		
Chronic infections (Hepatitis, AIDS)		
Dispute at work, in the family or circle of friends		

Allergies or intolerances:	Yes	No	Unknown
Medication			
Pollen			
Animal hair			
House dust mite			
Metals			
Food products			

Other
If yes, which? _____

Have operations already been performed? ☐ No ☐ Yes

Which operation?	When?	In which hospital?

Pregnant ☐ Yes ☐ No ☐ Unknown

Smoking ☐ Yes ☐ No
Number of zigarettes:

Alkohol ☐ Yes ☐ No
Number of drinks:

Illnes in relatives (Mother, father, brother, sister): If „**yes**“, put a cross in the box!

☐	High blood pressure	☐	Diabetes
☐	Heart attack (If yes, in which age?)	☐	Thyroid gland disease
☐	Other heart disease	☐	Liver disease
☐	Stroke (If yes, in which age?)	☐	Kidney disease
☐	Blood clot (in leg or lungs)	☐	Elevated uric acid (Gout)
☐	Varicose veins	☐	Elevated blood lipids
☐	Cancer	☐	circulatory disorders
☐	Dementia	☐	Depression, other mental illnesses

Other diseases:

Vaccinations:

Please bring your vaccination card with you and hand it in at the registration.

Medication taken:

Do you take medication regularly? ☐ No ☐ Yes, following:

Name and dose	In the morning	At noon	In the evening	At night

Which medications are you currently taking occasionally and because of which health disorder?

Name and dose	Why?

Date, signature

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Data protection declaration of consent

For the processing of personal patient data according to Art 6. Abs. 1 lit. A, Art. 7 DSGVO

Name, first name, birthday

I hereby consent to the collection, storage and processing of my personal data for the purpose of fulfilling the practice's own treatment contracts, invoicing the KV Sachsen or other external invoicing offices as well as cooperation with other service providers in connection with the treatment (laboratory etc.) by the above-mentioned practice. I agree that the practice is released from the obligation of secrecy and may pass on information or reports about me to other attending specialists and hospitals, my health insurance company, the public health department and the following persons (first name and surname) or institutions appointed by me.

I agree to be called by name from the waiting room.

I consent to being reminded of appointments by text message or email.

I agree to be informed about clinical trials that would be applicable to me and/or my diseases.

My patient-related data will remain in my patient file and may be kept for more than 10 years.

I have been informed that I can revoke this consent at any time in writing to the practice (Art. 7 para. 3 DSGVO).

I am aware that my revocation of consent, which is possible at any time, does not affect the lawfulness of the processing that has taken place up to that point (Art. 7 para. 3 sentence 2 DSGVO).

Date, signature from the Patient