Hausarztpraxis Hochtaunus
Zeppelinstr. 24
61352 Bad Homburg
06172 / 14-3554

MEDIZINISCHES VERSORGUNGS ZENTRUM TAUNUS GmbH

Medical history for new patients

Dear patient, in order to provide you with the best possible care, we kindly ask you to fill out this questionnaire.

Surname, First Name: _____

Birthdate: _____

Adress: _____

Telephone Number: _____

E-Mail (optional): _____

profession: _____

former/current family doctor: _____

_____

Other treating doctors (name/specialisation/adress, if known): _____

_____

Chronic diseases

Lung diseases

☐ asthma ☐ COPD ☐ lung cancer

☐ other _____

Skin diseases

☐ eczema ☐ psoriasis ☐ other: _____

Cardiovascular diseases

☐ high blood pressure ☐ stroke ☐ heart attack ☐ coronary artery disease (CAD)

☐ congenital heart defect ☐ other: _____

Neurological diseases

☐ epilepsy ☐ Multiple Sclerosis ☐ Parkinson's disease ☐ dementia ☐ depression

☐ other: _____

Metabolic diseases

☐ Diabetes Type 1 / Type 2 ☐ Thyroid disease ☐ Goutt ☐ High Cholesterol

☐ other: _____

Please turn →

Other diseases

☐ glaucoma ☐ rheumatism ☐ chronic hepatitis ☐ HIV ☐ medication/drug addiction

☐ cancer _____

☐ liver/kidney diseases _____

☐ Allergies _____

☐ care level stage _____

☐ degree of disability (GdB) in %_____

☐ "Living will" available _____

☐ other: _____

☐ height: _____ ☐weight:_____

Other important information**:**

_____
_____
_____
_____

Medikamente

medication	dosage	in the morning	in the afternoon	in the evening	at night
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

X_____ **X** _____

Place, Date **Signature of the patient or legal representative**