PATIENTS' REGISTRATION FORM

infektiologikum
ZENTRUM FÜR
FACHÜBERGREIFENDE INFEKTIONSMEDIZIN

Welcome to our infectiological practice!

In order to enable us to comply with your wishes and to keep any necessary bureaucracy to a minimum, we would like to ask you to spare a few minutes. The following form containing questions about your health will help us to advise and take care of you. Please use CAPITAL letters. Thank you!

Reason for visiting the doctor/nature of symptoms (Please describe any medical problems you have!)

_____

Last / First Name: _____

Gender: ( ) male ( ) female ( ) divers Height: _____ cm Weight: _____ kg

Date of Birth: _____ Nationality: _____

Street / House Number: _____

Postal Code / City: _____

Phone (home): _____ (office) _____

Cell phone: _____ eMail: _____

Family Doctor (Adress): _____

Are you currently being treated by other doctors? (Name, Speciality): _____

We need your permission to send medical reports to other doctors involved in your treatment, and in ordert o give information over the phone.
I give my permission to employees of the *Infektiologikum* to waive medical confidentiality rules when dealing with the following persons: (seulement noms):

Family Doctor: _____

_____

_____

Which of your relatives, friends or partners may be given medical information by us?

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

( ) Please send doctors' letters **only** to attending physicians (doctors who are treating me)

( ) Please send a copy of doctors' letters to the address stored on my insurance card

Family Status

( ) Single ( ) Widowed ( ) Divorced / Separated

( ) Married ( ) Living with partner

Children: ( ) no ( ) yes – How many: _____

Occupation / Profession: _____

( ) employed ( ) self-employed ( ) unemployed / looking for work

( ) full-time ( ) part-time ( ) retired

Severe Disability: ( ) no ( ) yes – degree: _____ %

Type of Disability: _____

How did you hear about us? Who recommended us?

( ) Internet (search engine) ( ) Magazine / Paper ( ) Partner, friends, acquaintances

( ) Family Doctor ( ) Clinic ( ) AIDS help

( ) Public Health Office ( ) Self-help Group ( ) others: _____

Information about previous illnesses:

	Yes	No
High Blood Pressure	( )	( )
Diabetes mellitus	( )	( )
High Cholesterol	( )	( )
Cardiac (Heart) Disease	( )	( )
Pulmonary (Lung) Disease	( )	( )
Tumour Diseases	( )	( )
Rheumatic Diseases	( )	( )
Diseases of the Muskoskeletal System	( )	( )
Gastrointestinal Diseases	( )	( )
Kidney Diseases	( )	( )
Psychiatric Disorders	( )	( )
Diseases of the Nervous System	( )	( )
Diseases of the Liver	( )	( )

Do you suffer from any allergies (such as Hay Fever, or against certain medications)?

If yes, which ones? _____

Operations / Hospital stays: _____

_____

_____

_____

Has there been a high incidence of illness in your family (e.g. heart attack, high blood pressure, diabetes, cancer):

_____

_____

_____

What medications do you currently take?
(including contraceptive pills and otc-substances like vitamins, nutritional supplements etc.)

		morning	noon	evening	night
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____

Do you smoke? ( ) No ( ) Yes Amount per day: _____

Do you drink alcohol? ( ) No ( ) Yes Amount per day: _____

Do you take drugs? ( ) No ( ) Yes

Type / Amount per day: _____

May we remind you of appointments?

( ) No

( ) Yes, by letter
( ) Yes, by eMail
( ) Yes, by phone

Place / date _____ Signature: _____