

## New Patient Intake Form

Dear Madam, Dear Sir,

welcome to our practice. The information below is very important for your treatment. If you are unsure about an answer, please put a “?” there. Please confirm the completeness and accuracy of your information with your signature at the end of the document.

Last name & first name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Previous GP: \_\_\_\_\_

Health insurance: \_\_\_\_\_

Occupation: \_\_\_\_\_

### Previous surgeries / hospital stays

Reason	Year	Hospital/Clinic

### Are there any cases of the following in your family (parents / siblings / children):

Stroke                      Yes  No                       Heart attack                      Yes                       No

Cancer                      Yes  No

If yes, who had what condition and at what age:

Who	Condition	Age

**Do you take medication regularly** (including sprays/patches/ointments/cream)  Yes  No

If yes, please bring your current medication plan with you, or enter the medications in the table below:

Medication	Dosage	Reason	Since when?

Do you occasionally need pain or sleeping medication? Yes  No

If yes, which? \_\_\_\_\_

Do you have or have you had any of the following illnesses / infections?

- High blood pressure     CAD     Cardiac arrhythmia     Heart attack  
 Thrombosis     Liver disease     Kidney disease     Stroke  
 Asthma / COPD     Thyroid disease     Diabetes mellitus     Seizures  
 Migraine     Rheumatic disease     Cancer     Osteoarthritis  
 HIV     Hepatitis     Mental health disorder (e.g., depression, anxiety disorder)

Please indicate which conditions you have/had and where they were treated:

Condition	Place of treatment

When was your last health check / cancer screening?

\_\_\_\_\_

How did you hear about us?

- Doctor     Family     Friends     Phone book     Internet     Practice sign  
 Other \_\_\_\_\_ Recommended by: \_\_\_\_\_

Thank you for the information. All information will of course be treated confidentially and be subject to medical confidentiality and data protection.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_