



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 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 order to 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	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac (Heart) Disease	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary (Lung) Disease	<input type="checkbox"/>	<input type="checkbox"/>
Tumour Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Diseases of the Muskoskeletal System	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Diseases of the Nervous System	<input type="checkbox"/>	<input type="checkbox"/>
Diseases of the Liver	<input type="checkbox"/>	<input type="checkbox"/>



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: \_\_\_\_\_