Information about your medical history

onkologische praxis oldenburg • delmenhorst

You have an appointment in our medical practice. To understand your medical situation it is important for our team to know about your medical history, especially the current diagnoses. It would be helpful if you could prepare for the doctor's appointment by filling in this questionnaire.
Please note that your answers are voluntary.

First name and surname: _____ **Date of birth:** _____

Family doctor/general practitioner: _____

Medical specialist (to be informed): _____

Height: _____ W**eight**:_____

Do you have any of the following diseases and since when?

	Yes	No	Onset	Remarks / Specification
Diabetes				
Heart attack / Stroke				
Thrombosis / Lung embolism				
Hypertension				
Thyroid disease				
Allergies				

Former illnesses / Hospitals stays / Operations: **Year ↓**

Family diseases
Did or do any of your family members have a disease like high blood pressure, cancer, heart attacks or thrombosis/lung embolism?

Who?	Disease?
_____	_____
_____	_____
_____	_____

➔ to be continued on the following page

Are you allergic to any medication or substance? yes: ☐ no: ☐

If yes, please specify: _____

Are you taking any medication including herbal drugs?*:

Name and dosage of medication	Morning	Noon	Night	Remarks

* You may use a medication schedule. Please ask at the reception.

⇨ **If you want to note any questions, please use the reverse side!**

Declaration und disengagement of medical confidentiality

Name of patient in block capitals: ……

☐ I declare my consent to transfer my personal medical record to authorized co-treating doctors, hospitals und medical facilities.

☐ I declare my consent to transfer my laboratory specimens to cooperating laboratories.

I was informed that I can withdraw this disengagement of medical confidentiality at any time.

Date: _____ **Signature:** _____

The "Onkologische Praxis Dres. Otremba / Reschke / Zirpel / Ruff / Peinert / Kühn" is allowed to provide information about my medical results to the following persons:

1. Name: _____

   Address: _____ Phone: _____

2. Name: _____

   Address: _____ Phone: _____

☐ I decline that the "Onkologische Praxis" will pass on any medical information about myself to any person.

☐ I was informed that I can withdraw this disengagement of medical confidentiality at any time.

Date: _____ **Signature:** _____