


<b>Questionnaire for patients</b>	 <b>AmBeNet Hausarztpraxis</b> Das Ambulante BehandlungsNetz Dr.Dr.med. Hans-Detlev Stahl/ Susanne Prawitt und Dr. med. Lena Rothe
-----------------------------------	--

Name, first name, birthday:	Today's date:	
Telephone number:	E-Mail address:	
Profession / current activity:	Marital status:	Child, year of birth:
Size:	Weight:	
How did you hear about us?	Name/address of previous GP:	

**Current complaints / reason for consultation (put a cross in the box)**

<b>Fever:</b>		
<input type="checkbox"/> Yes, how much?	<input type="checkbox"/>	No
<b>Pain:</b>		
<input type="checkbox"/> Head	<input type="checkbox"/>	Throat
<input type="checkbox"/> Neck, back (cervical/thoracic/lumba)	<input type="checkbox"/>	Chest
<input type="checkbox"/> Abdomen / lower abdomen	<input type="checkbox"/>	Joints
<b>Airways:</b>		
<input type="checkbox"/> Sniff	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/> Cough	<input type="checkbox"/>	Sputum(tenacious/yellowish/greenish/brownish)
<b>Gastrointestinal:</b>		
<input type="checkbox"/> Nausea / vomiting	<input type="checkbox"/>	Pain in bowel movements
<input type="checkbox"/> Diarrhoea	<input type="checkbox"/>	Blood in the stool
<input type="checkbox"/> Constipation	<input type="checkbox"/>	Mucus in the stool
<b>Urinary tract / genitals:</b>		
<input type="checkbox"/> Painful urination	<input type="checkbox"/>	Discharge
<input type="checkbox"/> Burning during urination	<input type="checkbox"/>	Erection problems
<input type="checkbox"/> Blood in urine	<input type="checkbox"/>	Flank pain
<b>Eyes:</b>		
<input type="checkbox"/> Visual disturbances	<input type="checkbox"/>	Dry eye
<input type="checkbox"/> Red eye	<input type="checkbox"/>	Foreign body feeling
<b>Ears:</b>		
<input type="checkbox"/> Hearing disorder	<input type="checkbox"/>	Tinnitus / ear noises
<b>Injuries / wounds:</b>		
<input type="checkbox"/> Head	<input type="checkbox"/>	Upper extremities (shoulder/arm/hand)
<input type="checkbox"/> Upper Body	<input type="checkbox"/>	Lower extremities (knee/foot/ankle joint)
<b>Paralysis:</b>		
<input type="checkbox"/> Numbness	<input type="checkbox"/>	Restrictions movement
<b>Skin / allergies:</b>		
<input type="checkbox"/> Rash, where?	<input type="checkbox"/>	Itch
<b>Weight:</b>		
<input type="checkbox"/> Reduction	<input type="checkbox"/>	Increase
<b>Psyche:</b>		
<input type="checkbox"/> Tiredness / sleep disorder	<input type="checkbox"/>	Depression / memory impairment

**Own previous illnesses:** Yes or no (put a cross in the box)

Do you have a doctor or hospital records? Please hand in at the registration desk!

	Yes	No
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Heart failure	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety disorder	<input type="checkbox"/>	<input type="checkbox"/>
Psychosis	<input type="checkbox"/>	<input type="checkbox"/>
Other mental disorder (PTSD etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Chronic lung diseases (Asthma, COPD)	<input type="checkbox"/>	<input type="checkbox"/>
Inflammatory rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal illnesses	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthrosis (joints)	<input type="checkbox"/>	<input type="checkbox"/>
Urinary tract disease	<input type="checkbox"/>	<input type="checkbox"/>
Chronic infections (Hepatitis, AIDS)	<input type="checkbox"/>	<input type="checkbox"/>
Dispute at work, in the family or circle of friends	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No	Unknown
<b><u>Allergies or intolerances:</u></b>			
Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pollen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Animal hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
House dust mite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

**Have operations already been performed?**  No  Yes

Which operation?	When?	In which hospital?

**Pregnant**  Yes  No  Unknown

**Smoking**  Yes  No  
Number of cigarettes:

**Alcohol**  Yes  No  
Number of drinks:

**Illnes in relatives (Mother, father, brother, sister):** If „yes“, put a cross in the box!

<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Heart attack (If yes, in which age?)	<input type="checkbox"/>	Thyroid gland disease
<input type="checkbox"/>	Other heart disease	<input type="checkbox"/>	Liver disease
<input type="checkbox"/>	Stroke (If yes, in which age?)	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	Blood clot (in leg or lungs)	<input type="checkbox"/>	Elevated uric acid (Gout)
<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	Elevated blood lipids
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	circulatory disorders
<input type="checkbox"/>	Dementia	<input type="checkbox"/>	Depression, other mental illnesses
Other diseases:			

**Vaccinations:**

Please bring your **vaccination card** with you and hand it in at the registration.

**Medication taken:**

Do you take medication regularly?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, following:		
Name and dose	In the morning	At noon	In the evening	At night

Which medications are you currently taking occasionally and because of which health disorder?

Name and dose	Why?

**Date, signature**

## Data protection declaration of consent

For the processing of personal patient data according to Art 6. Abs. 1 lit. A, Art. 7 DSGVO

---

Name, first name, birthday

I hereby consent to the collection, storage and processing of my personal data for the purpose of fulfilling the practice's own treatment contracts, invoicing the KV Sachsen or other external invoicing offices as well as cooperation with other service providers in connection with the treatment (laboratory etc.) by the above-mentioned practice. I agree that the practice is released from the obligation of secrecy and may pass on information or reports about me to other attending specialists and hospitals, my health insurance company, the public health department and the following persons (first name and surname) or institutions appointed by me.

---

I agree to be called by name from the waiting room.

I consent to being reminded of appointments by text message or email.

I agree to be informed about clinical trials that would be applicable to me and/or my diseases.

My patient-related data will remain in my patient file and may be kept for more than 10 years.

I have been informed that I can revoke this consent at any time in writing to the practice (Art. 7 para. 3 DSGVO).

I am aware that my revocation of consent, which is possible at any time, does not affect the lawfulness of the processing that has taken place up to that point (Art. 7 para. 3 sentence 2 DSGVO).

**Date, signature from the Patient**