Dr. med. Thomas Franke
Privatärztliches Zentrum für biologische Medizin

MEDICAL HISTORY

Dear patient, we are pleased to welcome you to our practice. We would like to ask you to complete this form carefully. This will provide us with important information that may have an impact on your treatment.
We also need certain data for a smooth administrative process and for patient services requiring consent.

PATIENT

Surname, first name _____

Date of birth _____

Your address _____

Privat phone number _____

Business phone number _____

Mobil phone _____

Email adress _____

Profession _____

PERSON LIABLE TO PAY (usually the patient him/herself, in the case of children the legal guardian)

Surname, first name _____

Date of birth _____

Your address _____

Privat phone number _____

Business phone number _____

Mobil phone _____

Email adress _____

Profession _____

Name of health insurance or insurance company _____

YOU ARE

☐ legally insured ☐ privately insured ☐ not insured

☐ Voluntarily insured with statutory health insurance ☐ Entitled to benefits ☐ Private supplementary insurance

NAME, ADRESS OF FAMILY DOCTOR

_____

_____

NAME, ADRESS OF FAMILY DENTIST

_____

_____

HAVE YOU HAD OR DO YOU HAVE THE FOLLOWING ILLNESSES?

Asthma (severe shortness of breath)	☐ yes ☐ no	Hepatitis A/B/C	☐ yes ☐ no
Diabetes (diabetes mellitus)	☐ yes ☐ no	Viral load, if applicable	☐ yes ☐ no
Rheumatism	☐ yes ☐ no	Liver diseases	☐ yes ☐ no
Osteoporosis	☐ yes ☐ no	Tuberculosis	☐ yes ☐ no
Blood diseases	☐ yes ☐ no	Seizure disorders (epilepsy)	☐ yes ☐ no
Blood clotting disorders	☐ yes ☐ no	Thyroid diseases	☐ yes ☐ no
Blood thinners if necessary	☐ yes ☐ no	Bone diseases	☐ yes ☐ no
HIV infection	☐ yes ☐ no	Possibly bisphosphonates / bone drip	☐ yes ☐ no

Heart attack	☐ yes, when? _____	☐ no
Stroke	☐ yes, when? _____	☐ no
Paralysis	☐ yes, cince when? _____	☐ no
Cancer	☐ yes, cince when an what? _____	☐ no

How high is your blood pressure?Do	☐ low	☐ normal	☐ high
you wear a pacemaker?	☐ yes	☐ no	
Are you pregnant?	☐ yes, weeks _____		☐ no
Do you smoke?	☐ yes, how many/days/years _____		☐ no

Other messages to us, e.g. other illnesses

_____

_____

Are you an anxiety patient? ☐ yes ☐ no

Do you take medication regularly? If so, which ones and how often? ☐ yes ☐ no

Do you have a medication list? ☐ yes ☐ no

_____

_____

Do you have any allergic reactions to medication? If so, which ones? ☐ yes ☐ no

Do you have an allergy passport? ☐ yes ☐ no

_____

_____

I agree that I will be reminded of my appointment by telephone, post, e-mail or text message.

☐ yes ☐ no

How did you find out about our practice?

MAY WE INFORM YOU ABOUT OUR OTHER OPTION?

☐ Vitamin / restorative infusions

☐ Aesthetic treatments

☐ Anti-aging treatments

☐ Nutritional advice

☐ Dental cleaning / prophylaxis

☐ Blood value analysis

☐ Laser treatments

☐ Skin examinations

Our team will be happy to advise you on all services offered.

Patient's declaration of consent for the transmission of treatment data and findings
(§ 73 para. 1b SGB V)(§ 73 Abs. 1b SGB V)

I agree that the practice of Dr. med. T. Franke may obtain treatment data and findings from me that are available, for example, to a specialist, a dentist or another service provider with whom I am receiving treatment. The persons concerned are obliged to forward this information to the practice of Dr. med. T. Franke.

I agree that the practice of Dr. med. T. Franke may obtain the data and findings required for my treatment from my family doctor, dentist and other service providers with whom I am receiving treatment. The persons concerned are obliged to pass on this information.

Date / Signature of patient or legal guardian

(With my signature I confirm the completeness and accuracy of the information I have provided above) All information is of course subject to medical confidentiality and the applicable data protection regulations.

Please note: For appointments that are not canceled at least 24 hours in advance, we reserve the right to charge a cancellation fee of 100 € in accordance with § 615 BGB.