Practice Dr. Hartter & Dr. Rabaioli

Internal Medicine - Family Medicine

Medical History Form

Please complete this form fully and legibly. Your information helps us provide safe treatment.

1. Personal Information

Last name		**First name**	
Date of birth		**Phone / Mobile**	
Street, house no.		**Postal code, city**	
E-mail		**Health insurance**	
Insured	☐ statutory ☐ private ☐ other	**Previous GP**	

2. Social History

Marital status	☐ single ☐ partnership ☐ married ☐ divorced ☐ widowed ☐ other: _____
Children	☐ no ☐ yes, number: _____
Sports / leisure	☐ no ☐ occasional ☐ regular Type/frequency: _____

3. Important Previous Illnesses

☐ none known	☐ high blood pressure	☐ diabetes mellitus
☐ heart disease	☐ stroke/TIA	☐ asthma/COPD
☐ thyroid disease	☐ kidney disease	☐ liver/gastrointestinal disease
☐ rheumatic/autoimmune disease	☐ cancer	☐ thrombosis/embolism
☐ clotting disorder	☐ mental health disorder	☐ neurological disorder

Other illnesses / important findings:

4. Medications, Allergies and Intolerances

Medication / active ingredient	Dose	morning	midday	evening / as needed

Allergies	☐ none known ☐ yes, to: _____
Intolerances	☐ none known ☐ yes, to: _____

5. Surgeries, Hospital Stays, Implants

Year	Surgery / hospital stay / implant	Complications / notes

6. Family History

☐ no significant illnesses known	☐ high blood pressure	☐ diabetes mellitus
☐ coronary artery disease / heart attack	☐ heart disease	☐ stroke
☐ cancer	☐ thrombosis / clotting	☐ mental health disorders

Affected relatives / age / details:

7. Lifestyle and Risk Factors

Smoking	☐ no ☐ former ☐ yes: _____/day	**Alcohol**	☐ never ☐ rarely ☐ regularly
Diet	☐ mixed ☐ vegetarian ☐ vegan ☐ other	**Sleep / stress**	☐ normal ☐ stressed: _____
Height	_____ cm	**Weight**	_____ kg
Care level / GdB	☐ no ☐ yes: _____	**Advance directive**	☐ no ☐ yes
Health care proxy	☐ no ☐ yes	**Other**	_____

8. Vaccinations, Preventive Care and Additional Information

Vaccination record	☐ brought along ☐ not brought ☐ unknown
Last tetanus vaccination	Year: _____ ☐ unknown
Preventive examinations	☐ Check-up 35 ☐ skin cancer screening ☐ colorectal cancer screening
Additional information	What else should the practice know? _____

9. Communication, Data Protection and Consent

Contact by the practice: ☐ phone ☐ SMS ☐ e-mail ☐ post

Findings / information may be passed on to: _____

☐ I consent to the processing of my data as part of treatment and practice organization. I have received the practice's data protection information or can view it.

I confirm that the information I have provided is correct and complete to the best of my knowledge. I will inform the practice of any changes.

Place, date	Patient's signature	Legal representative, if applicable

Thank you. Please hand in the completed form at reception.