Taunus Medizin

Checklist

- ☐ Completed anamnesis Sheet
- ☐ Completed data protection Declaration
- ☐ Previous findings (if available)
- ☐ Medication plan (if available)
- ☐ Vaccination Certificate
- ☐ Insurance Card
- ☐ ______________________________

We need the above Documents to find an optimal appointment for you. This enables you to have less waiting time and enough time to discuss your concerns.

If you have any questions, please do not hesitate to contact us.

Phone: 06081/987987-0
Email: kontakt@taunusmedizin.de

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Dear Patient,
we want you to feel comfortable with us and we want to devote ourselves to your complaints and wishes as quickly as possible. With this questionnaire, we want to avoid "unpleasant eavesdropping" during registration and carry out your admission, quickly and without errors. We need the following information to create your patient file. Please answer the questions completely and conscientiously. If you have any questions, we will be happy to help you.

Personal details:			
Surname, First name			
Date of birth		Gender	☐ female ☐ male ☐ diverse
Height in cm		Weight in kg	
Marital status		Number of children	
Street, House Number			
Zip Code, Adress			
Occupation			
Contact details	Private		
	Business		
	Mobile		
	E-mail		
Emergency contact	Name		
	Phone Number		
Allergies?	☐ None ☐ Yes, which ones:		
Do you smoke?	☐ None ☐ Yes, how many a day:		☐ not anymore, since:
Do you drink alcohol?	☐ None ☐ Yes, how much and how often:		
Health Insurance	☐ Statutory Health Insurance, Name of Insurance Company:		
	☐ Private Health Insurance, Name of Insurance Company:		
Insured as	☐ Member ☐ Family Member ☐ Pensioner ☐ other:		
Co-treating physicians		Specialty:	
		Specialty:	
		Specialty:	
Participation in the DMP Program?	☐ Asthma ☐ Chron. obstruct. Lung disease (COPD) ☐ Breast cancer ☐ Diabetes Type I ☐ Diabetes Type II ☐ Coronary Heart Disease/ Heart Failure		

When was your last check-up?	
Health-Check:	Cancer Screening Male/ Female:
Skin Cancer Screening:	Colonoscopy:
Stool examination (IFOB-Test):	Screening for abdominal aortic aneurysm:
Known pre-existing conditions:	
☐ Asthma	
☐ chronic bronchitis (COPD)	
☐ other lung diseases	Which:
☐ Gallbladder stone(s)	
☐ Kidney stone(s)	
☐ Prostate enlargement	
☐ Spinal- and back problems	Which:
☐ Vein problems	Which:
☐ Mood disorders (e.g. depression)	
☐ Gastrointestinal diseases	
☐ Migraine	
☐ Seizure disorders (e.g. epilepsy)	
☐ Nervous disorders (e.g. Parkinson's)	Which:
☐ PAD (arterial circulatory disorder)	
☐ Blood lipid increase	
☐ Renal failure	
☐ Gout (increased uric acid)	
☐ Type I diabetes mellitus	requires insulin: ☐ yes ☐ no
☐ Type II diabetes mellitus	requires insulin: ☐ yes ☐ no
☐ Rheumatism / joint diseases	Which:
☐ Hyperthyroidism	
☐ Other thyroid disorders	Which:
☐ Heart disease (e.g. heart failure)	Which:
☐ High blood pressure	
☐ Cardiac Arrhythmia	
☐ Stroke	
☐ Blood thinning -/ clotting disorder	Which:

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☐ Autoimmune disease	Which:
☐ Infectious disease	Which:
☐ Skin disease	Which:
☐ Cancer / Tumor disease	Which:
☐ Heart attack	Which:
☐ Thrombosis	Which:
☐ Other diseases	Which:
☐ Essential operations	Which: When: Where:
	Which: When: Where:
	Which: When: Where:

Medication

Please tell us about all medications / ointments / sprays that you take regularly. Regardless of whether these have been prescribed or are over the counter, such as vitamin preparations, etc.

Medicine Full name, active ingredient, Manufacturer if applicable	Dosage / amount active ingredient (e.g. mg, ml	morning	noon	Evenin g	night
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

If you have a printed out, up-to-date medical plan, please bring it with you.

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Vaccination
Have you been regularly vaccinated against the flu? ☐ Yes ☐ No
Has there been a vaccination complication thus far? ☐ Yes ☐ No If so, which one?

Please remember your vaccination certificate(s) and bring it/them with you!

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Declaration of consent

For storage, transmission, processing and collection of patient data

Personal details:			
Name, First name			
Birth date			
Street, Housenumber			
Zip Code, Adress			
Health insurance		Insurance number	

1. Storage, transmission and collection of patient data

Dear Patient,

We would like to give you the best medical treatment possible. It may be necessary for us to transmit necessary data to other doctors or service providers who are co-treating you, or request this patient data from them. For this we need, among other things, your consent for storage of your patient data.

By choosing one of the following options and signing this form, you give our Office

Taunus Medicine Practice, Rudolf-Diesel-Straße 11, 61267 Neu Anspach

the necessary consent.

- o I agree that the necessary treatment data may be transmitted to or requested from all doctors or service providers who are also treating me.
- o I agree that the required treatment data may only be transmitted to or requested from the following doctors or service providers:

Please enter your Practitioner(s) name and the corresponding Address here:

- o I refuse to allow treatment data to be transmitted to or requested by doctors or service providers who are also treating me.

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2. Third party authorization(s)

You have the option of naming individual relatives or other persons to whom we may give information about your treatment, after their identity has been established, by means of an identity card. You determine the extent of the disclosure of information yourself.

Please state Name, First Name and Date of Birth of third party here:	Extent:
	☐ Prescription only ☐ Referral only ☐ all treatment data
	☐ Prescription only ☐ Referral only ☐ all treatment data
	☐ Prescription only ☐ Referral only ☐ all treatment data

3. Patient service (RECALL)

If you wish, we will inform you about certain appointments in the future (e.g. preventive medical check-ups). We will then contact you in writing, by telephone, by email (unencrypted as standard, encrypted via S / MIME if you wish), SMS (unencrypted) or other new communication channels (unencrypted, encrypted if possible). For this we need your written consent in accordance to EU General Data Protection Regulation (GDPR).

- o I agree that I will be informed about certain appointments in writing, by telephone, by e-mail, SMS or other new communication channels.
- o No, I do not consent to being informed about certain appointments in writing, by telephone, by e-mail, SMS or other new communication channels.

4. Revocation / Retraction

I was made aware of the fact that I can revoke/retract this declaration of consent, in whole or in part, at any time, with effect for the future.

Place, Date Signature of Patient or the Legal Representative