Medical history - Anamnesis

I need some information in order to treat you optimally. Of course all this information falls under medical secrecy. Your data will not be given to third parties. There is no further processing of your data.

Name, first name:	
Date of birth:	
Address:	
Zip-code, area:	
Children: Full name of parents / legal guardian	
Phone number(s):	
E-mail:	
Profession:	
Health insurance:	
Your doctors in charge:	
Reason for your visit. Which complaints are you suffering from?	
What worsens your complaints?	
What improves your complaints?	
Which therapies are carried out now?	
Are you pregnant?	
Are you suffering from allergies? Which ones?	
Are you wearing orthopedic insoles?	
Have operations been carried out? If so, which ones and when? Do you have scars?	
Are you doing sports? Which one? Are you doing sports professionally?	
Medicine taken regulary:	
Acute medicine:	

Further illness, please mark:

O temporal-mandibular joint disorders

O high blood pressure

O infectious disease

O frequent headache

O frequent common cold

O diabetes mellitus

O accident head-neck

O whiplash injury

O cerebral concussion

O traumatic brain injury

O asthma

O epilepsy

O orthopedic disease

O cardio-vascular-disease

O disturbed arterial blood circulation

O venous disease (e.g. thrombosis, varices)

O aneurysm

O rheumatic illness

O implants

O kidney / renal disease

O tonsillectomy

O tumor(s)

O stent

O prothesis/implant

O osteoporosis/osteomalacia

O gout

O depression

O psychosis

German law does not allow me to treat persons who suffer from HIV/AIDS or other infectious diseases (see IfSG)

O Other: _____

_____
Date

_____
Signature of the patient

Thank you for your cooperation!