PKD AM STÄDEL	**Patient questionnaire** **Praxis-Klinik für Diagnostik / MVZ**	**Städelstraße 10** **60596 Frankfurt**

Surname ☐ Ms ☐ Mr	
First name	
Date of birth	
Address	
Phone number	landline: mobile:
Email address	
Profession	/
Health insurance	name: ☐ private ☐ statutory
How did you find out about us?	☐ family doctor ☐ by referral ☐ recommendation ☐ internet ☐ other:_______________

What is the **reason** for which you have come to see us today?
☐ an acute disease ☐ a chronic disease ☐ prevention ☐ pain ☐ a follow-up check

Who has been/used to be your **family doctor** up to now?

Are there **other physicians** that you see regularly?

Do you suffer from any of the following **conditions**?
☐ back/joint diseases ☐ gastrointestinal diseases
☐ bladder-kidney diseases ☐ skin diseases ☐ cardio-vascular diseases
☐ lung diseases ☐ metabolic diseases ☐ cancer
☐ blood/coagulation disorders ☐ others:

Do you suffer from any **chronic** diseases? ☐ yes ☐ no
If yes, please specify:

Do you regularly take any **medication**? ☐ yes ☐ no
If yes, please specify:

Are you **allergic** to anything? ☐ yes ☐ no
If yes, please specify:

Do you consume any **alcohol or tobacco**?
alcohol: ☐ never ☐ rarely ☐ regularly ☐ daily
tobacco: ☐ never ☐ rarely ☐ regularly ☐ daily

Have you had to undergo any **surgery**?
☐ appendix ☐ thyroid gland ☐ gall bladder ☐ others:

Are there any known cases of the following **diseases** in your family's medical history?
☐ stroke ☐ heart attack ☐ cancer ☐ others:

Have you already had a **health examination/check-up**? ☐ yes ☐ no If yes, when was the last time?
Have you already had a **cancer screening**? ☐ yes ☐ no If yes, when was the last time? ☐ gynecology ________________________ ☐ urology ____________________________ ☐ gastroscopy/colonoscopy _______________
Have you been **vaccinated** in the course of the last 5 years? ☐ yes ☐ no If yes, please specify: ☐ tetanus ☐ diphtheria ☐ polio/IPV ☐ TBE/ticks ☐ hepatitis A ☐ hepatitis B ☐ covid-19 ☐ other vaccinations __________________________________ Note: Please make sure to have your **vaccination card** with you.

Declaration of consent on the collection/transmission of patient data in accordance with article 13 GDPR

I agree to have data on my treatment submitted by mail and/or fax to other physicians / psychotherapists, laboratories, associations of physicians of the statutory health insurance system, health insurance companies, the medical service of the health insurance companies, medical associations, pharmacies and clearing agencies for private medical services in line with my medical treatment.
I agree to have my laboratory samples sent to cooperating and specialized laboratories of complementary disciplines for examination and diagnose.
I am entitled to have my personal data corrected or blocked in and deleted from my physician's and respective cooperation partners' databases at any time as long as there are no conflicting legal provisions.
I am aware that I can fully or partially revoke this declaration of consent at any time and with future effect without indicating any reasons.

_________________________ ____
(place/date) (signature of patient or legal representative)

The **persons** indicated in the following may be informed **about my state of health and my treatment records** (please indicate degree of kinship). 1. person ____________________________________ date of birth _______________ 2. person ____________________________________ date of birth _______________
I agree that for my **treatment, other physicians may be provided with my data.** _________________________ ____ (place/date) (signature of patient or legal representative)
I would like to be reminded of **follow-up appointments** without any obligation. ☐ yes ☐ no If yes, please keep me informed by ☐ email ☐ mail _________________________ ____ (place/date) (signature of patient or legal representative)