Patient Information

Univ.-Doz. Dr.
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Imed 12
Innere Medizin | Hämatologie &
Internistische Onkologie | Intensivmedizin

Name:	Sir Name:
Telefone:	| | | | | X | | | | | | | Insurance Nr.:
Address:	E-Mail:
Name of your General Practician in CAPITAL LETTERS:	

The reason for your visit today:

DSGVO:
"I consent to the doctor treating me, transmitting my personal data (social security number, date of birth, address, diagnosis and related information) to other doctors or medical institutions, in whose treatment I am, or I am going be in the future. Furthermore, I agree that my treating doctor receives a report on the result of the referral when I am referred to other doctors or medical institutions.
This consent can be revoked at any time. The legality of the transmission of my data remains unaffected by this until the revocation is received."

Datum: Wien am, _____ Unterschrift: _____

Please hand in Page 1at the reception.
The assistant will copy and safe your data.

Be so kind as to fill out Page 2, until you will be called out for your treatment and consultation and hand over the paper to our medical team.

If you have any questions, please do not hesitate to contact our medical team, which is always available for you.

Follow-up appointments are given at the reception when you leave our clinic.

Are the following **illnesses** known in your **family**?

	Ja	Nein		Ja	Nein
Back/joint diseases	o	o	Gastrointestinal Diseases	o	o
Cardiovascular diseases	o	o	Skin Diseases	o	o
Urinary bladder-kidneys	o	o	Lung Diseases	o	o
Metabolic diseases	o	o	Cancer	o	o

Other known diseases:

Have you experienced one oft he following Infections?

	Ja	Jahr	Nein		Ja	Jahr	Nein
Covid-19	o	____	o	Lyme disease	o	____	o
Influenza	o	____	o	Whooping cough	o	____	o
Hepatitis (A,B,C,..)	o	____	o	HIV	o	____	o

Previous illnesses (including operations) with date:

For female patients only:

Menstruation regularly yes / no:
Menopause yes / no (if yes, when, naturally or after e.g. surgery):

Current weight (gained or lost? If so, when?): _____

Problems with bowel movements (yes / no; which ones): _____

Problems urinating / urinating (yes / no; which ones): _____

Do you have to get up during the night to go to the toilet (yes / no): _____

Excessive sweating (yes / no; if yes, at night?): _____

Do you suffer from allergies? If yes, which: _____

Are there personal risk factors? (please check):

	No	Yes
Nicotine	o	o (how many cigarettes a day? _____)
Alcohol	o	o (how much per day?_____)
Swollen ankles/legs?	o	o
shortness of breath during exertion	o	o

Do you take medication on a regular basis? If yes, please enter in detail:

Name	Dosis	Morning	Mid-day	evening

Danke.