

## YOUR MEDICAL HISTORY DATA

to provide the most important information about you

\_\_\_\_\_  
Your name and first name

\_\_\_\_\_  
Your date of birth

\_\_\_\_\_  
Your telephone number

\_\_\_\_\_  
Your email address

\_\_\_\_\_  
Your family doctor's name and address

\_\_\_\_\_  
A contact person (e.g. relative) with telephone number

### YOUR PRE-EXISTING CONDITIONS, IF KNOWN

- ☐ Elevated blood pressure
- ☐ Diabetes mellitus
- ☐ Elevated blood lipid level
- ☐ History of heart attack
- ☐ History of stroke

- ☐ Liver disease
- ☐ Kidney disease
- ☐ Epilepsy
- ☐ Depression
- ☐ other mental condition

☐ **NONE**

- ☐ Atrial fibrillation
- ☐ haemodilution: \_\_\_\_\_
- ☐ Pacemaker

☐ Other diseases: \_\_\_\_\_

☐ Drug intolerances and allergies: \_\_\_\_\_

- ☐ Smoker
- ☐ Non-smoker

- ☐ Your Height: \_\_\_\_\_ cm
- ☐ Your Weight: \_\_\_\_\_ kg

### YOUR MEDICATIONS (PLEASE SPECIFY DOSAGES)

☐ **NONE**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

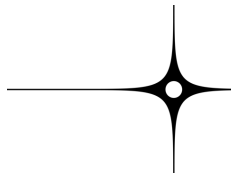
### YOUR CIRCUMSTANCES

- ☐ living alone
- ☐ in partnership
- ☐ married

- ☐ Your professional activity: \_\_\_\_\_
- ☐ Job seeking
- ☐ legal representative: \_\_\_\_\_
- ☐ Pflegegrad: \_\_\_\_\_  
(Care level)

\_\_\_\_\_  
Location, Date

\_\_\_\_\_  
Your signature  
(or, if applicable, your legal representative's signature)



## DECLARATION OF CONSENT

### on the collection and transmission of patient data

\_\_\_\_\_  
Your name and first name

\_\_\_\_\_  
Your date of birth

I agree that my patient data may be collected and processed at the "**neuropraxis neukölln**" (Karl-Marx-Straße 272, 12057 Berlin) for medical reasons. The practice has provided me with an information sheet on data protection available for viewing, on which I could ask questions:

1. about the scope and nature of my data
2. about the legal basis of the processing
3. about the possibilities to lodge an objection and the consequences thereof.

I agree, that

1. Treatment data and findings can be **requested from** other doctors, psychotherapists and service providers for the purpose of documentation and further treatment
2. Treatment data and findings may be **transmitted to** other doctors, psychotherapists and service providers treating me. This includes laboratories that provide certain values that are required for treatment and diagnosis.

I am aware that I can revoke this declaration in whole or in part at any time. I have been informed about the consequences of revocation.

I am also aware that the transmission of data via telephone, fax or email is not absolutely secure. If necessary, I nevertheless consent to the receipt and transmission of doctor's letters and findings to and from other doctors and nursing services.

I hereby **consent to the transmission of data to other doctors or therapists:**

☐ yes      ☐ no      (please tick)

I hereby **consent that I may be contacted by the practice:**

☐ yes      ☐ no      (please tick)

\_\_\_\_\_  
Location, Date

\_\_\_\_\_  
Your signature  
(or, if applicable, your legal representative's signature)