neuropraxis neukölln

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

YOUR PRE-EXISTING CONDITIONS, IF KNOWN ☐ **NONE**

- ☐ Elevated blood pressure
- ☐ Diabetes mellitus
- ☐ Elevated blood lipid level
- ☐ History of heart attack
- ☐ History of stroke
- ☐ Liver disease
- ☐ Kidkey disease
- ☐ Epilepsy
- ☐ Depression
- ☐ other mental condition

☐ 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
- ☐ Your professional activity: _____
- ☐ Job seeking
- ☐ 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). The practice has made an information sheet on data protection available for viewing, about which I could also 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 by** 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 also includes, for example, laboratories that are consulted for 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 for the future. I have been informed of 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 via:

- Phone ☐ yes ☐ no (please mark with a cross)
- FAX ☐ yes ☐ no (please mark with a cross)
- Email encrypted ☐ yes ☐ no (please mark with a cross)

- Email unencrypted ("non-critical findings", e.g. laboratory results that we may send you)
  ☐ yes ☐ no (please mark with a cross)

_____ _____

Location, Date Your signature
(or, if applicable, your legal representative's signature)