

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

- | | |
|---|---|
| <input type="checkbox"/> Elevated blood pressure | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Elevated blood lipid level | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> History of heart attack | <input type="checkbox"/> Depression |
| <input type="checkbox"/> History of stroke | <input type="checkbox"/> other mental condition |

Other diseases: _____

Drug intolerances and allergies: _____

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> Smoker | <input type="checkbox"/> Your Height: _____ cm |
| <input type="checkbox"/> Non-smoker | <input type="checkbox"/> Your Weight: _____ kg |

YOUR MEDICATIONS (PLEASE SPECIFY DOSAGES)

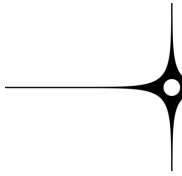
NONE

YOUR CIRCUMSTANCES

- | | | |
|---|--|--|
| <input type="checkbox"/> Living alone | <input type="checkbox"/> Your professional activity: _____ | <input type="checkbox"/> Pflegegrad: _____ |
| <input type="checkbox"/> In partnership | <input type="checkbox"/> Job seeking | (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 | <input type="checkbox"/> yes | <input type="checkbox"/> no | (please mark with a cross) |
| - FAX | <input type="checkbox"/> yes | <input type="checkbox"/> no | (please mark with a cross) |
| - Email <u>encrypted</u> | <input type="checkbox"/> yes | <input type="checkbox"/> no | (please mark with a cross) |
| - Email <u>unencrypted</u> ("non-critical findings", e.g. laboratory results that we may send you) | <input type="checkbox"/> yes | <input type="checkbox"/> no | (please mark with a cross) |

Location, Date

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