Dr. med. Antje Rathert
Internistin und Hausärztin

Winsstraße 45 | T.030 – 441 41 66 | info@Praxis-rathert.de
10405 Berlin | F.030 – 443 273 41 | www.praxis-rathert.de

Medical history form

Name, firstname: ______________________________

Date of birth: ______________________________

Hight / weight: ______________________________

General questions

Have you been in hospital? ______________________ yes / no

Have you ever been operated? ______________________ yes / no

Have you been traveling far away lately? ______________________ yes / no

Do you have allergies? ______________________ yes / no

Do you have food intolerances? ______________________ yes / no

Do you have medicinal product intolerance? ______________________ yes / no

Do you have pets? ______________________ yes / no

Do you smoke? Did you smoke? ______________________ yes / no

Do you drink alcohol? ______________________ yes / no

Do you eat vegetarian / vegan food? ______________________ yes / no

Have you ever had a coloscopy? ______________________ yes / no

Were there already been a skin cancer screnning? ______________________ yes / no

Have you ever been to a check up? ______________________ yes / no

Did you had further precautionary examinations? ______________________ yes / no

Vegetative anamnesis

Did you have weight changes lately? ______________________ yes / no

Do you suffer from appetite or nausea? ______________________ yes / no

Do you have any problems with urination? ______________________ yes / no

Do you have problems with urination ? ________________ yes / no

Do you suffer from shortness of breath? ________________ yes / no

Do you have a cough or sputum? ________________ yes / no

Do you suffer from fever? ________________ yes / no

Do you have sleeping disorders? ________________ yes / no

Do you suffer from unrest? ________________ yes / no

Do you suffer from increased exhaustion or fatigue? ________________ yes / no

Do you have any of the following diseases or infections

- ◯ High blood pressure
- ◯ Coronary geart disease
- ◯ Arrhythmia
- ◯ Heart attack
- ◯ Stroke
- ◯ Thrombosis
- ◯ Liver disease
- ◯ Kidney disease
- ◯ Asthma / COPD
- ◯ Tuberculosis
- ◯ Mood disorders
- ◯ Thyroid disease
- ◯ Diabetes mellitus
- ◯ Seizures
- ◯ Irritable bowel
- ◯ migraine
- ◯ chronic infection
- ◯ rheumatism
- ◯ osteoporosis
- ◯ arthrosis
- ◯ cancer
- ◯ glaucomo
- ◯ bleeding
- ◯ HIV
- ◯ hepatitis
- ◯ measles
- ◯ mumps
- ◯ rubella
- ◯ whooping cough
- ◯ chickenpox

OTHER ________________________________

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Do you have following diseases occured in your family (parents, brothers / sisters, grandparents)

- ◯ High blood pressure
- ◯ Heart disease
- ◯ Stroke
- ◯ Thrombosis
- ◯ Dementia / alzheimer
- ◯ Asthma / COPD
- ◯ diabetes mellitus
- ◯ allergies
- ◯ depression
- ◯ chronic diseases
- ◯ other autoimmune diseases

OTHER ______________________________

Which drugs / diatary supplements do you take regularly?

____
____
____
____
____

Do you have a vaccination certificate?

yes / no

Please bring it with you at your next visit. We would like to check your vaccination status.

Would you like to be informed about precautionary deadlines?

yes / no

If yes on which way?

- ➔ Mail / Mail address ______________________________
- ➔ Postcard ______________________________
- ➔ Phone / Phone number ______________________________

Thank you for your cooperation

Dr. med. A. Rathert