PATIENT HISTORY FORM

PERSONAL INFORMATION:

Patient's name:

Date of birth:

Address:

Phone number:

Housing situation:
☐ own household
☐ in a household with: _____

Family members help in the household with:

Employment (type):

Emergency contact:

(name, surname)

(phone number)

Family doctor:

Transfer documents: ☐ yes ☐ no

Native language:

Date: _____
Name of nurse: _____

☐ Patient history compiled with a third party:

(name, surname)

Size: _____ Weight: _____ BMI: _____

IMPORTANT INFORMATION:

ALLERGIES: ☐ yes ☐ no

IMPORTANT MEDICATION:

AIDS:

☐ hearing aid left / right

☐ glasses / lenses

☐ walker / walking stick

OTHERS:

CURRENT SYMPTOMS:

PRIMARY DIAGNOSIS:

SECONDARY DIAGNOSIS / OPERATIONS:

FAMILY HISTORY:

DIET:

☐ yes ☐ no

If yes, please specify:

HABITS:

☐ non-smoker ☐ smoker

ADDICTION PROBLEM:

☐ yes ☐ no