Welcome,

we would like you to answer the following questions to give you the best medical treatment.

All information will be treated confidentially.

Surname, Name:

Address:

Telephone: **Mobile-phone:**

Family-Doctor: **Date of Birth:**

Marital status: **Profession:**

Previous Births (year/pregnancy running/type of birth/sex/weight/bodysize/breast feed yes/no)

Current contraception:

Sports Activities:

Age of first menstruation:

Age of menopause:

Childhood diseases:

Vaccinations:

Surgery:

Other diseases : (please tick) High blood pressure heart disease diabetes thyroid disease

Asthma thrombosis/embolism/stroke osteoporosis allergies

Current drugs:

Stimulants:

Nicotine: Alcohol: Others:

Diseases of the family: high blood pressure heart disease stroke thrombosis/embolism

disability osteoporosis cancer (what-who-age)

Interested in natural healing process: yes/no

Interested in homeopathy: yes/no

Recall – do you want to be notified for your next precautionary date: yes / no phone/

letter/

e-mail

Thank you