NEW PATIENT QUESTIONNAIRE

NAME:

Address:

Social security number / private Insurance: _____ / _____
Insurance number Date of birth

Residence in Vienna: permanent/transient - months:
Mobile/Cell: **E-mail:**
Profession/ company:

Married (name of the partner):
Children: (name and age):

1. Do you **feel ill at the moment**? Please state the nature of your symptoms and how long you have had them.

2. Relevant **past or on-going medical history or illnesses**:

3. Previous **operations/surgery**:

4. Do you regularly take **medication**? If so, please state which ones. Please bring your medication to your doctor's appointment.

5. Date of the last **preventive examination or medical check** (blood test, etc):

(continue)

6. **Family history**: Of your blood relatives (not partner), do any have a history of the following:

- Cancer
- Diabetes
- Hypertension
- Cardiovascular disease: angina, heart attack or stroke
- Anaemia

7. **Habits:**

- Smoker? -Yes How many daily?
  -No If you are an ex-smoker, when did you stop?

- Alcohol -If regularly, how much?
  -Occasionally
  -Never

- Do you practice any **regular exercise** or sport? How often?

- Would you describe **your diet** as healthy?

8. **Vaccinations.** Please give dates, if known.

- Tetanus, Diphteria, Polio, Whooping cough
- FSME
- Hepatitis A +B
- Others

9. Known **allergies:**

10. **Women only:**

- Cervical smear. Date of the last one: Always normal?
- Mammography. Date: Always normal?
- Family Planning. Please state method:
- Menopause. Month / Year of last period.
  Hormon replacement:

Other comments:

Thank you for your help.

This information is totally confidential.

Important: please let me know if you change your address or telephone number

José M. Ozcariz Eizaguirre
Arzt für Allgemeinmedizin - General Practitioner