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

_____ A contact person (e.g. relative) with telephone number

YOUR PRE-EXISTING CONDITIONS, IF KNOWN

☐ **NONE**

- ☐ Elevated blood pressure
- ☐ Diabetes mellitus
- ☐ Elevated blood lipid level
- ☐ History of heart attack
- ☐ History of stroke
- ☐ Liver disease
- ☐ Kidkey disease
- ☐ Epilepsy
- ☐ Depression
- ☐ other mental condition
- ☐ Atrial fibrillation
- ☐ haemodilution: _____
- ☐ Pacemaker

☐ Other diseases: _____

☐ Drug intolerances and allergies: _____

- ☐ Smoker
- ☐ Non-smoker
- ☐ Your Height: _____ cm
- ☐ Your Weight: _____ kg

YOUR MEDICATIONS (PLEASE SPECIFY DOSAGES)

☐ **NONE**

_____

_____

_____

YOUR CIRCUMSTANCES

- ☐ living alone
- ☐ in partnership
- ☐ married
- ☐ Your professional activity: _____
- ☐ Job seeking
- ☐ legal representative: _____
- ☐ Pflegegrad: ____ (Care level)

_____ Location, Date

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

neuropraxis neukölln | Karl-Marx-Straße 272 | 12057 Berlin | tel 684099-6 / -70 | fax 684099-81 | info@neuropraxis-neukoelln.de

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) for medical reasons. The practice has provided me with an information sheet on data protection available for viewing, on which I could 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 from** 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 includes laboratories that provide 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. I have been informed about 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 <u>transmission of data to other doctors or therapists</u>** via:

- Phone	☐ yes	☐ no	(please mark with a cross)
- FAX	☐ yes	☐ no	(please mark with a cross)
- Email <u>encrypted</u>	☐ yes	☐ no	(please mark with a cross)

I hereby **consent <u>that I may be contacted by the practice</u>** via

- Phone	☐ yes	☐ no	(please mark with a cross)
- Email <u>encrypted</u>	☐ yes	☐ no	(please mark with a cross)
- Video consultation	☐ yes	☐ no	(please mark with a cross)

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

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