Medicum Brake
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MEDICUM BRAKE HAUSÄRZTE

Medical history form

Last name, first name:			Date of birth:	
Health insurance:			Phone:	
Pre-existing conditions:				
Operations:				
Allergies/intolerances:				
Immunization status (please include immunization record):				
Medications (name/active ingredient)		Morning	Midday	Evening
Height:	**Weight:**	☐ Alcohol	☐ Nicotine	☐ Drugs
Family history (are chronical conditions such as diabetes/high blood pressure/cancer known?):				
Social history Occupation:		Marital status:		Children:
Receiving in-home care? (if so, please provide level of care)				
Do you have a living-will? ☐ Yes ☐ No		**Do you have a health care power of attorney?** ☐ Yes ☐ No		
Year of last check-up examination:				
Name of last primary care physician:				