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Germany

Medical History Form

A. Personal information:

1. Name (as in passport): .....
2. Date of Birth: .....
3. Country: ..... 4. Nationality: .....
5. Gender: ☐ Male ☐ Female
6. Height: ..... cm 7. Weight: ..... Kg
8. Marital status: ..... 9. Number of children: .....
10. Address (P.O. Box number): .....
11. Job description: .....
12. Working status:

☐ Student	☐ Unemployed	☐ Retired
☐ Employed	☐ Own Business	☐ Disabled

13. Tobacco use: ☐ Yes ☐ No

    If yes, packs per day ..... and years of use .....
14. Alcohol use: ☐ Yes ☐ No

    If yes, amount per week .....

B. Medical information:

1. I suffer from: (Please tick all that apply to you)

☐ High Blood Pressure	☐ Asthma	☐ Others
☐ Diabetes	☐ Cancer	
☐ Coronary Heart Disease	☐ Previous Angina or Heart Attack	

2. What are your current complaints? (when did it start? / dates): ☐ None

.....

.....

.....

3. Have you been given a clear diagnosis? ☐ Yes ☐ No

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4. Surgical history (including dates): ☐ None

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5. Current medication: ☐ None

i. ..... iv. .....

ii. ..... v. .....

iii. ..... vi. .....

6. Current therapies: ☐ None

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7. Allergies: ☐ None

.....

8. Do you have difficulty taking anti-inflammatory medication? ☐ Yes ☐ No

9. Please list any significant medical problems in your family (cancer, diabetes, heart diseases): ☐ None

a. .....

b. .....

c. .....

C. Health Information: (Please mark all that apply to your health):

1. Constitutional:

- ☐ Fever, Chills, Sweats
- ☐ Weight loss
- ☐ Change in appetite
- ☐ Excessive fatigue
- ☐ None of the above

2. Eyes, Ears, Nose, & Throat:

- ☐ Recent changes in vision
- ☐ Glaucoma
- ☐ Metal fragments in eyes
- ☐ Nosebleeds
- ☐ Hearing loss
- ☐ Poor balance
- ☐ None of the above

3. Cardiovascular:

- ☐ Chest pain or Angina
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Irregular pulse
- ☐ Elevated Cholesterol
- ☐ Calf pain when walking
- ☐ None of the above

4. Respiratory:

- ☐ Sleep apnea
- ☐ Asthma, wheezing
- ☐ COPD
- ☐ Chronic cough
- ☐ Blood in sputum
- ☐ Lung cancer
- ☐ Pneumonia or bronchitis
- ☐ None of the above

5. Gastrointestinal:

- ☐ Ulcer or gastritis
- ☐ Nausea or vomiting
- ☐ Jaundice or liver problems
- ☐ Gallbladder problem
- ☐ GERD/heartburn
- ☐ Blood in stool
- ☐ Colon cancer
- ☐ None of the above

6. Genitourinary:

- ☐ Bladder infections
- ☐ Blood in urine
- ☐ Difficulty with urination
- ☐ Kidney stones
- ☐ Prostate problems
- ☐ Abnormal Pap smear
- ☐ None of the above

5. Musculoskeletal, skin, Neurological:

- ☐ Swelling in multiple joints
- ☐ Chronic rashes
- ☐ Seizures
- ☐ Excessive flexibility of joints
- ☐ Eczema or Psoriasis
- ☐ Leg pain/sciatica
- ☐ Broken bones, which?
- ☐ Skin cancer
- ☐ Weakness of a limb
- ☐ Dislocated joints, which?
- ☐ Breast lump/nipple discharge
- ☐ Numbness of a limb
- ☐ None of the above

8. Endocrine Hematological Immunology:

- ☐ Diabetes
- ☐ Easy bleeding/bruising
- ☐ Thyroid problems
- ☐ Blood transfusions
- ☐ Hormone Replacement Therapy
- ☐ Decreased resistance to infection
- ☐ Taken Prednisone
- ☐ Anemia
- ☐ None of the above

9. Psychiatric:

- ☐ Anxiety
- ☐ Depression
- ☐ Claustrophobia
- ☐ None of the above

D. Declaration:

1. I, ... born on ....., herewith confirm that I have requested Premier Healthcare Germany to handle my medical travel logistics to Germany and to represent my interests in front of the Hospital and doctors as well as German authorities if required. I authorize them to have access to my medical files. I also authorize them to request medical information on my behalf, both verbally and in writing from the healthcare providers involved in my treatment in order to streamline the process.
2. I also authorize them to represent me in front of the German authorities, if I am unable to attend myself.

3. Date: ..... Signature: .....

If you have any questions or require help in filling out this form, please do not hesitate to contact Premier Healthcare at given office number: +49 (0)40 53 79 766 0
Or send us an email at enquiry@premier-healthcare.eu

Important note:
All patient information provided to Premier Healthcare Germany are kept confidential and are stored in a secure place. Information will only be exchanged with healthcare providers who are or will be directly involved in assessing and/or treating the patient. Patient information will not be passed on to any outside third party other than described above without prior consent of the patient.