

**Dear Patient,**  
**Welcome to our practice, we're glad to have you here**

**To begin with we need more information about yourself and your medical records**

Last Name, First Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Phone Home : \_\_\_\_\_ Cell \_\_\_\_\_ Work: \_\_\_\_\_

Your profession: \_\_\_\_\_ Email address: \_\_\_\_\_

Health insurance: \_\_\_\_\_

What is the reason for your visit? \_\_\_\_\_

How did you find out about us? \_\_\_\_\_

We are also working with natural remedies (naturopathy).

Are you interested?  yes  no  in certain issues

Have you ever had a colonoscopy?  yes  no

**When and where?** \_\_\_\_\_

Have you ever had a mammography?  yes  no

**When and where?** \_\_\_\_\_

Are you vaccinated against cervical cancer?  yes  no

Do you smoke?  yes  no How many cigarettes per day? \_\_\_\_\_

Do you take any medication? If yes, please list kind and amount:

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Did you have any surgeries? If yes, please list what kind and when:

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Do you have any special conditions or any allergies?

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Did you ever give birth before? If so, how did you deliver?

Did you ever have a miscarriage?

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Are there any diseases in your family? Please list:

	mother	father	siblings	grandparents	aunt
Stroke					
Heart attack					
Breast cancer					
Colon cancer					
Cancer in general					
thrombosis					

**Please list any other information or concern you think we might need to know:**

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- Please bring all important preliminary findings with you to your first appointment.
- I hereby acknowledge and agree that examination appointments that I cannot keep must be canceled at least 24 hours in advance. Otherwise, missed appointments will be billed to me privately

Signature : \_\_\_\_\_

Date : \_\_\_\_\_

**Thank you for your help**