Dr. med.
Johannes Weilhartner
Facharzt für Innere Medizin

Patient data and medical history

o Mr. o Mrs.

Last Name:…………………………………………**First Name**:………...............................

Address:……………………………..………………………………………..…………..

Zip-Code: ………………**City**…………………………**Country:**……………………………….

Insurance number: ………………………… **Date of birth:** …………………………...

Insurance: …………………………………………..…

Telephone number: …………………………………………………………………...

Profession: ……………………………………………………………………….

Familiy doctor: ..……………………………………………………………...

Emergency contact: …………………………… Phone. ……………………………

Current complaints (location, duration, intensity, continually or recurring, first occurrence,….)

Year	Previous diseases and surgery

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Medication	morning	midday	evening	if needed

Medical family history (cancer, high blood pressure, heart attack / bypass, stroke, diabetes, …)	

Smoking? o Yes….cigarettes since …. years o occasionally o No o Ex-smoker

Alkohol? o daily, type and quantitiy………………… o occasionally o No

Allergies? o No o Yes:………………………………………..……………………

If sending a report by mail desired:

E-Mail: …..……………..........................……@……………………………………………...…

You get the result encrypted: Code = **DDMM** of your birthday!

With my signature, I confirm the accuracy of my data:

Date:………………………… Signature:…………………………………………………