Hausarzt
LANGGÖNS

Dear patients, welcome to our medical office!

Please take the time to complete the medical history form and return it to the front office staff.

The following information enables us to provide you the best care.

All information is private and confidential.

Thank you!

Last Name, First Name:	**Birth Date:**
Address:	**Primary Phone:**
Height:	**Weight:**
Employment Status/Occupation: **What is your highest level of education:** **If retired, occupation prior to retirement:**	

Have you had any past medical problems? ◯ yes ◯ no

If yes, list conditions and date of onset:

Do you have any family history of serious illness? ◯ yes ◯ no

If yes, please list:

Have you had any previous surgeries or hospitalizations? ◯ yes ◯ no

List details and dates:

Do you currently take any medications on a regular basis including non-prescriptions? ◯ yes ◯ no

Please list all:

Do you have any known allergies including food, medications and environmental? ◯ yes ◯ no

Please list all:

Are you currently in care of any other physicians or specialists? ◯ yes ◯ no

Name of physician and reason for care/diagnoses:

Do you have a disability? ◯ yes ◯ no Level of disability:

Have you been prescribed assistive devices (e.g. hearing aid, walker etc.)? ◯ yes ◯ no

Please list:

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Do you smoke? ◯ yes ◯ no How much?

How often do you consume alcohol? ◯ never ◯ less than weekly ◯ weekly ◯ daily

Do you use recreational drugs? ◯ yes ◯ no
What type? How often?

Do you live by yourself? ◯ yes ◯ no Do you have children? ◯ yes ◯ no

Do you exercise? How and how often?

Do you have hobbies? ◯ yes ◯ no
Please list:

Do you have any dietary restrictions? ◯ yes ◯ no
What kind?

Have you been experiencing increased stress in your personal or professional life? ◯ yes ◯ no
Please describe:

Have you been feeling sad or depressed in the past month? ◯ yes ◯ no

Have you experienced anxiety or a panic attack in the past month? ◯ yes ◯ no

Is there anything else you would like the doctor to know?

Date: _____ Signature: _____

Thank you!