HUISARTSENPRAKTIJK ANNA'S HOEVE

Medical History

Please fill in this form for every family member.

Date: .....

Name: ..... m / f

Date of birth: .....

Has one or more of the following diseases been established by your GP or a medical specialist?

☐ Diabetes	☐ no	☐ yes, from.....
☐ Lung disease (Asthma, COPD)	☐ no	☐ yes, from.....
☐ Renal disease	☐ no	☐ yes, from.....
☐ High Blood pressure	☐ no	☐ yes, from.....
☐ Heart and Vascular disease	☐ no	☐ yes, from.....
☐ Neurological disease (Stroke, Dementia)	☐ no	☐ yes, from.....
☐ Gastrointestinal disease	☐ no	☐ yes, from.....
☐ Thyroid disease	☐ no	☐ yes, from .....
☐ Cancer	☐ no	☐ yes, from.....
☐ Rheumatic disorder	☐ no	☐ yes, from.....
☐ Burnout	☐ no	☐ yes, from.....
☐ Psychiatric disorders	☐ no	☐ yes, from.....
☐ Eating disorder	☐ no	☐ yes, from.....
☐ Sexual Transmitted Disease (STD)	☐ no	☐ yes, from.....
☐ High Cholesterol	☐ no	☐ yes, from.....

☐ Other diseases: .....

.....

Do you visit a medical specialist in the hospital? If so, which one? Name? Which hospital?

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Do you use medication? If you do, which one? Dose? Frequency? Including over the counter medication.

- ..... - .....
- ..... - .....
- ..... - .....
- ..... - .....
- ..... - .....

Do you have an allergy? .....Hay Fever? ☐

Food intolerances?.....

Allergic reactions on medication? What kind of allergic reaction?.....

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Did you ever have a surgical intervention? If so, when? Which procedure?.....

- .....

- .....

Did you have any bone fractures? If so, when? Which bone? Left or right? Did you have related surgery?

- .....

- .....

Do you smoke?⎡ □ never ⎤ □ I stopped for ……. years □ yes, …… cigarettes a day

Do you use alcohol? □ If you do, how many a day?.....

Do you (sometimes) use drugs? □ If you do, which?.....

Have you been a victim of sexual harassment? □ yes, □ no .....

Did you receive the annual flu-vaccination? □ yes □ no

If so, do you still want to receive the vaccination? □ yes □ no

Do you have a donor card? □ A declaration of intention? □

Do any of these diseases occur in your family? (father, mother, grandfather, grandmother, brother, sister, uncle and aunt).

□	Diabetes	If so, which: .....
□	Lung disease (Asthma, COPD)	If so, which/what.....
□	High blood pressure	If so, which/what.....
□	Heart and Vascular disease	If so, which/what.....
□	Neurological disease	If so, which/what.....
□	Renal disease	If so, which/what.....
□	Psychiatric disorders	If so, which/what.....
□	Cancer	If so, which/what.....

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For Females:

Did you have an X-ray of the breasts? □ If so, when? What was the result? ……BIRADS. . .

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Did you have a cervical smear? □ If so, when? What was the result? ……PAP. . .

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Do you have an IUD? □ If so, which one? When was it placed?……

Do you use an oral contra conceptive? □ If so, which one?.....

Extra Information:

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