Medical history

You have registered with General Practice Lankhorst. We think it is important to be well informed about your medical history. That is why we ask you to fill in the questionnaire below and hand it in to us.

You must complete this form for each family member. NB: on the back of this form there is room for additional explanation.

Date: .....

Name: ..... m / f

Date of birth: .....

Have you been diagnosed with any of the following conditions now or in the past?

☐ Diabetes	☐ No	☐ Yes, since .....
☐ Lung diseases (such as Asthma, COPD)	☐ No	☐ Yes, since .....
☐ Kidney diseases	☐ No	☐ Yes, since .....
☐ High blood pressure	☐ No	☐ Yes, since .....
☐ Cardiovascular disease	☐ No	☐ Yes, since .....
☐ Neurological diseases (such as CVA, TIA	☐ No	☐ Yes, since .....
☐ Liver or intestinal diseases	☐ No	☐ Yes, since .....
☐ Thyroid diseases	☐ No	☐ Yes, since .....
☐ Malignancies	☐ No	☐ Yes, since .....
☐ Persistent joint complaints	☐ No	☐ Yes, since .....
☐ Emotional exhaustion	☐ No	☐ Yes, when .....
☐ Psychiatric illnesses	☐ No	☐ Yes, when .....
☐ Eating disorder	☐ No	☐ Yes, since .....
☐ Venereal diseases	☐ No	☐ Yes, since .....
☐ Elevated cholesterol	☐ No	☐ Yes, since .....
☐ Other diseases:		

Are you currently being treated by a **specialist**? If so, what name, which hospital and for what:

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Are you taking **medication**? (Including self-care products) If so, which ones? What dosage? Frequency?

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Are you **allergic**? ..... ☐ Hay fever

☐ Do you have a food hypersensitivity .....

Huisartsenpraktijk Lankhorst

□ Are you hypersensitive or allergic to medicines (which ones)?
What kind of reaction do you have to this drug?
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Have you ever had surgery? If so, what kind of surgery? Left or right? In what year? Which hospital? .....
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Have you also suffered bone fractures? Which bone? Left or right? What year? Was surgery needed? .....
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Do you smoke? □ never □ before: ..... years stopped □ yes, ... pieces per day
How many glasses of alcoholic beverages do you drink on average per day?: .....
Do you use drugs? □ Yes □No. If so, which ones? How often? .....
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Have you ever been a victim of (sexual) violence? □ Yes □No.....
Have you received the flu shot in the past year? □ Yes □No.....
Would you like to receive the flu shot again this year? □ Yes □No .....

Do you have a donor codicil □, living will □, euthanasia declaration□? If so, please give it to us so that the statement can be added to your file.

Do you have the following diseases in your family? (father, mother, grandfather, grandmother, brother, sister, nephew, niece)

□ **Diabetes**	**If so, in whom:** .....
□ **Lung diseases (asthma, COPD)**	**If so, in whom/what:** .....
□ **High blood pressure**	**If so, in whom/what:** .....
□ **Cardiovascular diseases**	**If so, in whom/what:** .....
□ **Kidney diseases**	**If yes, in whom/what:** .....
□ **Mental illnesses**	**If so, in whom/what:** .....
□ **Cancer**	**If so, in whom/what:** .....

For women: Has a mammogram (breast X-ray) ever been made? □ Yes □No
□ If so, when, what was the result? ..... BIRADS.....

Has a PAP smear ever been taken? □ Yes □No
□If so, when, what was the result? ..... PAP.....

Do you have an IUD? □ Yes □No
□ Hormone □ Copper? If so, when was it placed? .....

Are you on the birth control pill? □ Yes □No
If so, which one? .....

Additional information:
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