Medical History
dermatology

Name:

Date of birth:

Address:

Phone No:

E-Mail:

Job:

Family doctor:

Do you have any known allergies? ☐ Yes ☐ No

If so, please enter the medicine or substances you are allergic to.

Do you regularly take medication? ☐ Yes ☐ No

If so, please fill in the names of medications or give us your list of medicines.

Do you regularly go for skin cancer screening? ☐ Yes ☐ No

If so, please enter the year of your last skin cancer screening.

Are you taking any blood-thinning medication? ☐ Yes ☐ No
(e.g. Marcumar, Aspirin, ASS, Godamed, Plavisor similar)

Do you (or have you ever had) any of the following diseases?

☐ Diabetes mellitus (sugar disease)

☐ Heart trouble / heart attack

☐ Stomach discomfort (heartburn, stomach ulcers)

☐ Thyroid disease

Do you suffer from communicable infectious diseases? ☐ Yes ☐ No
(HIV, viral hepatitis, tuberculosis, etc.)

Have you had skin cancer in your family? ☐ Yes ☐ No

Do you smoke? ☐ No ☐ Yes, about. cigarettes a day
☐ Not anymore, I have stopped since

Do you drink alcohol? ☐ Never ☐ occasionally ☐ every day

Do you take drugs? ☐ Yes ☐ No

For women: Are you pregnant? ☐ Yes ☐ No ☐ Suspect

How did you find out about our doctor's office/ house ?

☐ Recommendation by resident doctors (statutory health insurance doctor)
☐ Recommendation / information from friends / relatives
☐ Recommendation / information through the Internet
☐ Recommendation / information through flyer
☐ Recommendation / information from an AOK employee / customer advisor
☐ Other

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Date, signature of the patient or legal representative

Patient/in: