dr. med.
weier
praxis am goetheplatz

Dear patient,
The following questions are for your treatment and are of course subject to medical confidentiality.
You are free in your decision to fill out this form. The information provided in this form is optional.

CONTACT INFORMATION

Name: ____________________________________ Date of birth: _______________________________________

Phone: *Mobile*: _______________________________ *Landline*: ____

Work: _______________________________ *Family / responsible person:* ____________________________

MEDICAL DATA

What brings you to us today? *Please only rough briefly description.*

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Did you see other doctors in this matter?

- ☐ Orthopedist ☐ Cardiologist ☐ ENT doctor ☐ Gastroenterologist ☐ Neurologist
- ☐ Chiropractic/ Osteopathy / Chinese medicine/ Natural medicine ☐ Other: _______________________________

Pre-existing illness / condition

____

____

Do you take medication on a regular basis? *Name, dose or rough name (e.g., Ramipril 5mg, Marcumar, blood thinner)*

____

____

Are you allergic? *e.g. Antibiotics, anesthetic injection at the dentist, contrast medium*

____

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