Orthopädisch Unfallchirurgische Praxis am Bethesda Krankenhaus
Dr. med. G. Koepp
Herr O. Krämer
Herr D. Crnkovic

MEDICAL HISTORY FORM

Dear Patient,

Welcome to the Orthopedic and Trauma Surgery Practice at Bethesda Hospital.
The information you provide below is very important for your treatment. If you are unsure about a particular answer, please place a question mark.
All information is subject to medical confidentiality according to §203 of the German Penal Code (StGB) and will be treated with strict confidentiality.

PERSONAL DETAILS

Name: _____
Adress: _____

Phone: _____ Occupation: _____ Height (cm): _____

Weight (kg): _____

Family doctor (name / location): _____

Voluntary information – should it be necessary to obtain medical records for your treatment, we will ask for your consent accordingly.

HEALTH INFORMATION

How long have you had your current complaints?_____ ☐ Days ☐ Weeks ☐ Months ☐ Years
Is today's visit related to an accident?
If yes, date of accident: _____ Time: _____

If it was an accident: was it a work-related accident? ☐ Yes ☐ No ☐ Unknown

Do you play sports? ☐ Yes ☐ No
If yes, what kind? _____

Have you had any orthopedic surgeries? ☐ Yes ☐ No
If yes, which ones (please include year, if possible)? _____

Do you have any medication allergies? ☐ Yes ☐ No
If yes, which ones? _____

Are you currently taking any blood-thinning medications such as:
☐ Aspirin (ASA) ☐ Marcumar ☐ Plavix ☐ Clopidogrel ☐ Heparin ☐ Others: _____

Have you ever had any of the following conditions?
☐ High blood pressure ☐ Thrombosis ☐ Stroke ☐ Heart attack ☐ Liver disease ☐ Kidney disease
☐ Diabetes ☐ Asthma ☐ COPD ☐ Cancer ☐ Osteoporosis ☐ Osteoarthritis ☐ Herniated disc
☐ Rheumatic disease ☐ Other (e.g. accident): _____

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Are you pregnant? ☐ Yes ☐ No
If yes, which month? _____

Are there any hereditary diseases in your immediate family? ☐ Yes ☐ No
If yes, which ones? _____

CONSENT FOR DATA USE FOR FURTHER PURPOSES

To ensure smooth continuation or initiation of treatment, I agree that essential medical information from my electronic patient file may be accessed by substitute doctors within this practice.
Digitally collected data will be deleted after the legally required 10-year retention period.
I agree that my data may be stored beyond 10 years unless I request its deletion.

I consent to the sharing of my data and findings **(after prior agreement with me)** with other healthcare professionals such as referring doctors, hospitals, laboratory/pathology specialists, or other providers (e.g. hearing aid specialists, speech therapists, social services, professional associations, pharmacies, social courts, medical transport services, sample couriers, insurance companies (e.g. travel cancellation insurers), rehabilitation centers).
*** Please cross out anything that does not apply!**

AUTHORIZATION

I authorize the following person(s) to collect prescriptions, referrals, and/or medical documents on my behalf:

_____-
Full name and date of birth

I confirm that the information I have provided is correct.

_____
Date/Signature:

PATIENT RIGHTS
Right to information, correction, deletion, restriction, and objection:
According to Article 15 of the GDPR, you have the right at any time to request information about the data stored about you by the BAG Koepp/Crnkovic/Krämer (contract partner).
According to Article 17 GDPR, you may also request the correction or deletion of personal data at any time.
You also have the right to object to the use of your data at any time without stating a reason, and to withdraw your consent for future processing.
You may submit your objection via post, email, or fax to the practice.