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MEDICAL HISTORY FORM FOR NEW PATIENTS

Internal Medicine / Family Practice Dr. Turniski-Harder

Welcome to our internal medicine family practice!

We are delighted to welcome you as a new patient. In order to provide you with the best possible care, we need the following information.

Please fill out this form completely and truthfully. All information is subject to medical confidentiality.

1. Personal Information

Last Name:	First Name:
Date of Birth:	Occupation:
Phone (Landline):	Mobile:
Address (Street, House Number, ZIP Code, City):	
Email:	

2. Medical History – Past & Current Conditions

Please check applicable conditions or note them in the free-text field.

Do you have, or have you had in the past, any of the following conditions?

Condition	No	Yes	Since When (Year)?
High Blood Pressure	☐	☐	
Cardiovascular Disease / Heart Attack	☐	☐	
Other Heart Conditions	☐	☐	
Cancer	☐	☐	

Condition	No	Yes	Since When (Year)?
Vascular Disease of the Legs (Circulatory Disorders)	☐	☐	
Diabetes	☐	☐	
Kidney Disease	☐	☐	
Gastrointestinal Disease	☐	☐	
Infectious Diseases	☐	☐	
Bleeding / Blood Clotting Disorders	☐	☐	
Lung Disease (Asthma, COPD)	☐	☐	
Thrombosis / Pulmonary Embolism	☐	☐	
Eye Disease	☐	☐	
Mental Health Conditions	☐	☐	
Neurological Disorders	☐	☐	
Surgeries / Accidents	☐	☐	
Other	☐	☐	

Current Medications:

Please list all medications (including over-the-counter drugs and supplements) you are currently taking regularly.

Medication Name	Dosage	Frequency

Alcohol Consumption:

☐ no consumption ☐ occasionally

☐ regularly (amount/week: _____) ☐ daily

Do you smoke? If yes, since when and how much per day?

Allergies:

Known Allergies (e.g. pollen, animal hair, food):

Drug Allergies / Intolerances:

Weight:

Height (cm): Weight (kg): BMI:

Weight Change in the Last 12 Months (gained/lost, how many kg?):

Physical Activity / Exercise in Daily Life:

3. Previous Examinations

Last Cardiac Catheterization:
No ☐ Yes ☐ Date: _____

Colonoscopy Performed:
No ☐ Yes ☐ Date: _____

Last Gynecological Exam:
No ☐ Yes ☐ Date: _____

Last Mammogram:
No ☐ Yes ☐ Date: _____

Last Urological Exam:
No ☐ Yes ☐ Date: _____

4. Family Medical History

Please indicate whether the following conditions are known among close family members (parents, siblings, grandparents), and note which family member if applicable.

Condition	Yes	No	Which Family Member?
Heart Attack	☐	☐	
Cardiovascular Disease / Circulatory Disorders	☐	☐	
Diabetes	☐	☐	
Tumors / Cancer	☐	☐	
Blood Clotting Disorders	☐	☐	
Thrombosis	☐	☐	

5. Social History

Marital Status: Number of Children:

Living Situation (alone / with family / shared housing, etc.):

Occupation / Work Demands:

Notable Social/Family Stressors That May Be Relevant to Treatment:

Additional Information (any current circumstances or other issues relevant to your treatment):

Place, Date: Patient Signature: