**Dr. med. Jürgen Neumaier**
**Dr. med. Ute Warnke, Dr. med. Julia Klee,**
**Dr. med. Anne Mackensen**
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Hausärzte
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Fliegerärztliche Untersuchungsstelle

# First contact-Sheet

Given name / Family Name:______________________

date of birth: _________________

eMail Address: _________________________

Phone:________________Mobile No:______________

**For referral patients:**

Family doctor:________________________

Do you participate in the DMP diabetes? □no □ yes

Are you enrolled in the general practitioner contract HZV? □no □ yes

Height (m) ……….. weight (kg) ………

**Do you smoke?**

□ yes, how much per day? ____ □ No

if yes, at what age did you start smoking? _____________

**Do you drink alcohol?**

□ yes, how much and what per day? ______ □ No

**Do you suffer from?**

□ arterial hypertension

□ heart attack

□ circulatory disorders

□ foot problems / foot wound

□ kidney problems

□ cardiac arrhythmias

□ high cholesterol

□ stroke

□ tumor disease

□ nervous disorder/depression

□ bladder or prostate disorder

□ Allergies Yes □ No □ , if yes, which: _______________________

□ other diseases or preconditions:_____________________________

□ degree of disability___________

**Medication (Dose)?**

1.________________________

2.________________________

3.________________________

4.________________________

5.________________________

6.________________________

**Is this precondition in your family?**

□ arterial hypertension □ high cholesterol □ Gout □ heart attack □ Stroke □ diabetes

□ other______________________

**Have you already had one of the above examinations?**

□ ultrasonic □no □ yes, when, where?______________________

□ gastroscopy □no □ yes, when, where?______________________

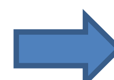
□ colonoscopy □no □ yes, when, where?______________________

□ cat scan □no □ yes, when, where?______________________

□ core spin □no □ yes, when, where?______________________

□ cardiac catheder □no □ yes, when, where?______________________

**Please see backside!**



**Recall system**

Would you like to be included in our recall system to remind you of vaccinations, cancer prevention or other check-ups? □ No □ yes

**release from confidentiality**

Consent to transfer data/medical information

My data can be given by Dr. Neumaier, Fr. Dr. Warnke, Fr. Dr. Klee und Fr. Dr. Mackensen to other persons.

□ No

□ yes, towards following private individuals ________________________

□ yes, rowards the family doctor_________________________________

□ yes, towards medical specialists_______________________________

□ yes, towards treating hospitals_________________________________

___________________________________________________________

Date Name in letters + signature

**Declaration of consent to the collection/transmission of patient data in accordance with § 73 Paragraph 1 b SGB V**

I ________________________________________________________ agree

(First name, family name, date of birth)

- that my treating doctor transmits my treatment data and findings to my family doctor for the purpose of documentation to be kept by the family doctor and further treatment.
- that the doctor treating me collects the treatment data and findings required for my treatment from my family doctor or other doctors or service providers and processes and uses them for the purposes of the medical services to be provided by my treating doctor.

I am aware that I can revoke this declaration in whole or in part at any time for the future.

___________________________________________________________

(place, date) (Signature of the patient or legal representative)

Note: My treating doctor may not transmit, process and use my treatment data and findings for purposes other than those mentioned above.