**NEW PATIENT INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Family Name: |  | First Name: |  |
| Date of Birth: |  | Nationality: |  |
| Czech Health Insurance: | 🞏 Yes 🞏 No (Patients not holding Czech Health Insurance are required to pay a consultation fee of 500 Kč per visit) |
| Address in the CZ: |  | Telephone: |  |
| Employer: |  |
| Reason for today’s visit: |  |
|  |
| Have you ever suffered from or received treatment for any serious illness, condition or disease or been hospitalized for any reason? 🞏 Yes 🞏 No  |
| If Yes, describe: |  |
| Please list any medications (incl. dosage) you are currently taking (incl. birth control and anti-depressants etc.): |
|  |
|  |
| Do you use any drugs other than as prescribed by a medical practitioner? 🞏 Yes 🞏 No  |
| If Yes, describe: |  |
|  |
| Do you have any allergies? 🞏 Yes 🞏 No  |
| If Yes, describe: |  |
|  |
| Do you have any allergies to any medications? 🞏 Yes 🞏 No  |
| If Yes, describe: |  |
|  |
| Do you have any history with any of the following conditions? |
| Heart Attach / murmur | 🞏 Yes 🞏 No | Arthritis | 🞏 Yes 🞏 No |
| Stroke | 🞏 Yes 🞏 No | Diabetes | 🞏 Yes 🞏 No |
| Arterial Disease | 🞏 Yes 🞏 No | Thyroid problems | 🞏 Yes 🞏 No |
| Epilepsy/seizures | 🞏 Yes 🞏 No | Gallbladder problems | 🞏 Yes 🞏 No |
| Bronchitis | 🞏 Yes 🞏 No | Kidney/urinary problems | 🞏 Yes 🞏 No |
| Asthma | 🞏 Yes 🞏 No | Hepatitis B or C  | 🞏 Yes 🞏 No |
| Any Lung Condition | 🞏 Yes 🞏 No | Mononucleosis | 🞏 Yes 🞏 No |
| Anaemia | 🞏 Yes 🞏 No | Any psychological condition | 🞏 Yes 🞏 No |
| If you answered “yes” to any of the above, please describe: |  |
|  |
| **DECLARATION:** I declare that the above information is true and complete and represents a full disclosure of my medical history to the best of my knowledge. |
|  |
| Signed in Prague on (date): |  |  |  |
|  |  |  | Patient’s Signature |