**NEW PATIENT INFORMATION**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 | | | |