Huisartsenpraktijk Mondriaanlaan

Register: General Practice Mondriaanlaan

Personal information.

- Name: _____ Gender: M / V
- Date of birth: _____
- Street: _____ Number: _____
- Zip code and city: _____
- Phone number: Home _____ Mobile: _____
- E-mail: _____
- National ID number (BSN): _____

Pharmacist: _____

Insurance Company.

Health insurance company: _____
Insurance number: _____
(We would like to take a copy of your insurance company. We will destroy the copy after registration.)

Extra information.

If you have previously registered with a General Practitioner in the Netherlands, then please ensure you deregister from that practice.

Contact details of the next of kin in case of an emergency:

Name _____ Phone number: _____

Do you give consent to your medical information being shared with other health professionals?

We will only share your medical information if we have your permission. Only health professionals may view your medical details, if this is deemed necessary for your treatment. This service has been developed for health professionals to obtain immediate access to medical information to enable them to give the best possible care.

O I Agree, my medical information is shared with other health providers.

O I do not agree my medical information is share with health providers.

Medical History.

To make your registration complete, we would like to obtain some medical information from you.

Have you ever suffered from:

O – Diabetes.
O – Depression or Anxiety
O – Thyriod Diseases
O – Lung disease
O – Eating Disorders
O – Skin disorders
O – High Blood pressure
O – Joint pain
O – Kidney diseases
O – Heart problems
O – Immune disorders
O – Any other disease: _____

Other important medical information?

O – No
O – Yes: _____ Year: _____
_____ Year: _____
_____ Year: _____

Are you currently under treatment of a specialist?

O – No
O – Yes Specialism : _____ Disease: _____

Are you currently taking any medication?

O – No
O – Yes I use: _____
_____

Have you ever had an allergic reaction?

O – No
O – Yes

- Medication: _____
- Anesthesia / plasters / iodine: _____
- Food: _____
- Other: _____

Do you have a donor card?

O – No
O – Yes I donate: _____

Do you have a religion?
O – No
O – Yes: _____
Is there anything in your religion we need to take into account with regards to any medical treatment?
O – No
O – Yes namely: _____

Have any of your parents, brothers or sisters ever suffered from any of the diseases below?

O – Diabetic Mother / Father / Brother / Sister
O – High Blood pressure. Mother / Father / Brother / Sister
O – High Cholesterol Mother / Father / Brother / Sister
O – Heart and vascular disease under 65 Age: _____
O – Stroke or Cerebral haemorrhage under 65 Age: _____
O – Lung disease Mother / Father / Brother / Sister
O – Kidney disease Mother / Father / Brother / Sister
O – Mental illness_____Mother / Father / Brother / Sister
O – Cancer; Type_____ Mother / Father / Brother / Sister
O – Other Disease: _____ Mother / Father / Brother / Sister

Do you smoke?
O – No, I have never smoked.
O – No but I smoked _____ cigarettes a day for _____ years
O – Yes: _____ cigarettes a day for _____ years.

Do you regularly use alcohol?
O – No
O – Yes; units a day _____

Have you ever been a victim of violence?
O – No
O – Yes; sexually / mental / physical

Are you dependent on anything?
O – medicines.
O – Drugs
O – Something else: _____