Medicum SHS
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MEDICUM SHS HAUSÄRZTE

Medical history form

Last name, first name:	Date of birth:
Health insurance:	Phone:

Pre-existing conditions:

Operations:

Allergies/intolerances:

Immunization status (please include immunization record):

Medications (name/active ingredient)	Morning	Midday	Evening

Height:	**Weight:**	☐ Alcohol	☐ Nicotine	☐ Drugs

Family history (are chronical conditions such as diabetes/high blood pressure/cancer known?):

Social history Occupation:	Marital status:	Children:

Receiving in-home care? (if so, please provide level of care)

Do you have a living-will? ☐ Yes ☐ No	**Do you have a health care power of attorney?** ☐ Yes ☐ No

Year of last check-up examination:

Name of last primary care physician: