Registration form Huisartsenpraktijk Boudesteyn

Personal data

Surname: _____ Male / Female
Birth name: _____ Initials: _____
First name: _____ Date of birth: _____
Citizen service number: _____
Insurance:_____ Policy number:_____
Streetname:_____ House number: _____
Zip code: _____ Domicile: _____
Phone number:_____ Mobile number:_____
(Personal) e-mail address: _____
Level of education: _____ Job: _____
Type of identification document: _____ Document number: _____

Is your partner / housemate already registered in our practice? Yes / No
If so;
Name from your partner/housemate:_____
Date of birth from your partner/housemate:_____
Reason for registration: Relocation? Yes / No / Different:_____

Details previous General Practitioner

Name:_____
Address:_____
Domicil:_____
Phonenumber:_____

Medical data

Length: _____cm Weight: _____kg

Do you have an allergy (e.g. for medication)? Yes / No
What are you allergic to: _____
_____

Do you take any medicines? Yes / No
Name: _____ Dosage: _____
Name: _____ Dosage: _____
Name: _____ Dosage: _____
Name: _____ Dosage: _____
Name: _____ Dosage: _____
Name: _____ Dosage: _____
Name: _____ Dosage: _____
Name: _____ Dosage: _____

Do you have a chronic illness or does it run in the family?

	With you:	With you in the family:
Diabetes Mellitus:	Yes / No	Yes / No
Heart/vascular disease:	Yes / No	Yes / No
Kidney disease:	Yes / No	Yes / No
High bloodpressure:	Yes / No	Yes / No
Asthma or COPD:	Yes / No	Yes / No
Epilepsy:	Yes / No	Yes / No
Rheumatoid arthritis:	Yes / No	Yes / No
Too high cholesterol:	Yes / No	Yes / No
Other diseases:	Yes / No	Yes / No

Which: _____

Are you getting a flu vaccination? Yes / No
If so, why?_____

Have you had surgery in the past? Yes / No
If so, when and for what?_____
_____
_____

Lifestyle
In our practice, we also focus on prevention, we would therefore appreciate your answers to the questions below.
Do you smoke? Yes / No (If so, how many cigarettes a day?_____)
Do you use alcohol? Yes / No (If so, how many drinks a day / week?_____)
Do you use drugs? Yes / No (If so, which and how much?_____)

Is there any additional information you would like to inform your new doctor about?
_____
_____
_____

Would you like an introductory meeting with your new doctor? Yes / No
Would you like to use MijnGezondheid.net? Yes* / No
**MijnGezondheid.net can only be used by persons of 16 years and older, with a Digi-D login.*

We would like to receive a copy of a valid proof identity or passport when handing in. We would like to point out again that you are responsible for the transfer of your medical data, please contact your previous doctor!

Patient signature:_____
Date: _____ Location: _____

Forms accepted by employee:_____