INSCHRIJFFORMULIER

HUISARTSENPRAKTIJK
P. OLIE
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Tel: 020-6150799

Personal Details

***** Cross out if it doesn't relate to your situation

Surname and/or maiden name	
Initials and given name	
Street name and number	
Zip code and city of residence	
Telefone number/ mobile number	
e-mail adress	
Marital status	***** Single / married / divorced / childeren**: ....**
Living situation	***** living alone / living together / one parent family/ other
Sex	***** Man / woman
Date of birth	
Place of birth / country	
Profession / trade / education	
belief / geloof	
Name of insurance company and policy number	
Social security number and control	
Details last G.P	
Name	
Residence	
Medical details	
Recent height and weight	
Other details	Glasses/ contacts ? y / n * hearing aid ? y / n*

	Do you have one or more of the following conditions? Or did you had one or more in the past? If so, since what year?/ In what year?	**Does one of these diseases run in the family? (close family)**
High blood pressure		
Cardiovascular diseases		
High cholesterol		
Lung diseases (for example: astma)		
Kidney diseases		
Gastrointestinal diseases		
Diabetes		
Eye or Ear problems		
Returning cystitus		
Cancer		
Psychiatric diseases		

	(vervolg)	(vervolg)
Tenseness		
Fears		
Depressive periods		
Eating disorders		
Sleeping disorders		
Persistent joint problems		
Thyroid diseases		
Other serious diseases		

Have you ever been in the hospital; if so, when, for what, where, name doctor? Yes / no*

Did you ever had surgery; if so, when, for what, wherer, name doctor? Yes / no*

Are you over sensitive to medication, if so, what medication? Yes / no *
Are you over sensitive to ***iodine*****?** Yes / no
Are you sensitive to other things, if so, what? Yes / no*

Do you use medication, if so, what medication and since when? Yes / no*
1. 4.
2. 5.
3. 6.

Do you get an annual flue vaccination on medical indication, if so, why? Yes / no*

Do you smoke; if so, what? And since when and how much per day? Yes / no* per dag:

Do you drink alcohol, if so, what, since when and how much per week? Yes / no* per week:

Do you use drus; if so, which ones, since when and how often? Yes / no* per dag:

Do you exercise regularly; if so, what, how long and how often? Yes / no*

Is ther someting else, of which you think is important that we must know of? Yes / no*

For women:
Have you given birth to any kids? If so, how many? Yes / no* Do you desire to have childeren? Yes/no*

Do you use birth control; if so, which? Yes / no* the Pil / spiral / other:

Do you still have your period; if not, when was your last period? Yes / no*

When did you have your last pap test, and what was the outcome?

Is ther anything else of importance to you that we should know of? Yes / no*

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Graag dit formulier persoonlijk aan de assistente afgeven

In gevuld door assistente……

Inleverdatum: .....Reden nieuwe huisarts: .....
Partner hier ook patiënt; zo ja bij welke arts? Ja / nee* .....
Toevoegen aan bestaand woonverband, adres:.....
Huisarts: ..... Apotheek: .....