# E Admission / Main questionnaire

CBT

Patient's data

**Any preliminary findings?**
If yes, bring this with you.

Date

## Patient

Last Name, First Name | Date of Birth

Street Address

Postal code, City

Phone Home | Phone Office

Mobil

E-Mail

Profession

Health Insurance

## Further information patient

Gender: ☐ female ☐ masculine ☐ inter ☐ trans - born: ☐ f ☐ m

Height: _____ cm

Weight: _____ kg

BMI: _____

Are you pregnant? ☐ no ☐ yes Due date: _____

## Reason for referral (to be filled out by the doctor)

## Transferring Physician

Name

Street

City

Fax

## Referring Physician

Name

Street

City

Fax

## Patients with private insurance

Last Name, First Name

Address (Please provide Insurance Policy owner, if different than address left.)

## Filled out by CBT

waist circumference: RR: Pulse rate:

Blood: Date/timet Implemented by (abbreviation):

303-Version 1.1 (08/2023)-F033_E_AO_e

# E Main questionnaire

## Do you suffer from:

- ☐ Shortness of breath
- ☐ Heart pain
- ☐ Belly pain
- ☐ Hair loss
- ☐ Night sweat
- ☐ Tachycardia
- ☐ Headache
- ☐ Constipation
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Sleep disorders
- ☐ Sexual disorders
- ☐ Cycle disorders
- ☐ Swallowing problems
- ☐ Salt appetite
- ☐ Listlessness
- ☐ Exhaustion

## Has your body weight changed in the last few month?

☐ no ☐ yes ☐ gained weight _____ kg in _____ month

☐ no ☐ yes ☐ lost weight _____ kg in _____ month

## Do you suffer from allergies?

☐ no ☐ yes, which: _____

_____

_____

## Do you smoke?

☐ no ☐ yes, how many cigarettes per day: _____

## Do you drink alcohol?

☐ no ☐ yes, how much per day: _____ ml

## Do you have any pre-existing conditions?

- ☐ Diabetes mellitus type I
- ☐ Diabetes mellitus type II
- ☐ High blood pressure
- ☐ Tyroid gland problems
- ☐ Thrombosis
- ☐ Zoeliac disease
- ☐ Depressive disorders
- ☐ Cardiovascular diseases which: _____
- ☐ Lung problems which: _____
- ☐ Fat metabolism problems which: _____ treated: ☐ yes ☐ no
- ☐ Gastrointestinal diseases which: _____
- ☐ Joint or muscle diseases which: _____
- ☐ Kidney problems which: _____
- ☐ Liver problems which: _____
- ☐ Cancer which: _____
- ☐ Food intolerances which: _____

303-Version 1.1 (08/2023)-F033_E_AO_e

# E Main questionnaire

## Other illnesses incl. hospitalization, operations, etc.

_____

_____

_____

## Last cancer screening:

Date _____ Type _____

♀

Number of children: ☐

Number of pregnancies: ☐

Number of births: ☐

Number of abortions: ☐

Utilization of fertility clinics? ☐ no ☐ yes

Last gynecological ultrasound examination: D D M M Y Y

First day of the last menstrual period: D D M M Y Y

Menopause, last menstrual period: M M Y Y

## Have you been to the tropics?

☐ no ☐ yes

## What medications are you currently taking?

| Medication | dosis | morning | noon | evening | night |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## Do you take nutritional supplements? Vitamins, minerals, biotin or St. John's wort?

☐ no ☐ yes, which _____

_____

**! Please do not take any biotin preparation for three days before blood sampling, otherwise hormone measurements could be falsified.**

# E Main questionnaire

## Are there any diseases in the family? (Parents, Grandparents, Siblings, Children)

e.g. Diabetes mellitus, high blood pressure, heart diseases, rheumatism, thyroid diseases, thrombosis susceptibilities

**How did you hear about us?**

- ☐ Family doctor / Referring physician
- ☐ Internet
- ☐ Advertisement
- ☐ Friends / Acquaintances

# Notice of patient information

www.cbtmed.de

## Report

As soon as all laboratory results are available, your physician will write a report letter based on results, the information from your questionnaire and your interview with him. This report letter includes diagnoses, assessment and therapeutic recommendations.

This letter will then be sent by post to your home or electronically to you, and if possible electronically via the telematics infrastructure to your GP or referring doctor.

☐ I have an e-mail address (see page 2) and agree that the practice may send me my documents by e-mail.
If necessary, only transport encryption and no content encryption will be used for sending.

## Agreement on data transfer

By accepting this agreement, you voluntarily acknowledge and consent to the use and transfer of personal data to third parties. However, failure to provide the consent may affect the best possible treatment with us or with other physicians. Possible third parties could be your physicians/hospitals and relatives, partners, children or others.

1. Name referring doctor: _____

2. Name general practitioner: _____

3. Name physiotherapist: _____

4. Name midwife: _____

5. Name psychologist: _____

6. Relative / third person:

| last name | first name | date of birth |
|---|---|---|
| | | |
| | | |
| | | |

☐ **No** If you do not agree with data transfer to third parties.

Agreement to request of reports by general practicioner, medical specialists or hospitals.

I agree ☐ yes ☐ no

Agreement to data transfer fort appointments at physicians or hospitals.

I agree ☐ yes ☐ no

# Notice of patient information

www.cbtmed.de

## Data privacy statement

I have taken note of the data protection declaration, with reference to the information and complaint form for personal data, which is available in the waiting area and on the homepage www.cbtmed.de. I am informed that I can revoke my consent in writing at any time for future processing in accordance with Art. 7 DS-GVO.

Patient:

last name

first name

date of birth

e-mail

street address

city

For minors and patients requiring care statutory representative:

last name

first name

date of birth

e-mail

street address

city

city, date

X signature patient/statutory representative

## Consent to appointment reminders via SMS or e-mail

In order to avoid missed appointments, we would like to remind you of your appointment by sending you an SMS and / or e-mail using the Doctolib calendar system. Please confirm your agreement with your signature.

☐ **Yes** I would like to receive an appointment reminder.

☐ e-mail (see above) or ☐ Mobile phone number:

I am informed that I can revoke my consent for future processing in accordance with Art. 7 GDPR (General Data Protection Regulation) in written form at any time.

city, date

X signature patient/statutory representative

☐ **No** I do not want to receive any appointment reminders.

I have received a copy of this form.

X signature patient/statutory representative