Registration as a new patient [name of general practice - vul in]

Date .......... General practitioner: [name of practitioner - vul in]

Address: [vul in] phone: [vul in] AGB-code: [vul in]

Family name................ First name ........ Male/Female Initials ......

Date of birth … /… /..... City and country of birth .........

BSN number: …………………

Address/street ........................... Housenumber/addition ... Postal code ......

City……………………………

Domestic tel number ............. Mobile phone number …………

Nr. in case of emergency…………..

E-mail………………………

Insurance company ............... Insurance number .................
Pharmacy (in place) …….......................

Previous general practitioner (name/address)……………………………………………….................................................................

I ask my previous general practitioner to de-register me and send my patient file to [name general practioner - vul in] Signature: …

**For assistant: ID number……………………. ID type (passport/ID-card/driver’s license) Initials assistant:**

**Marital Status**

Single

Unmarried partnership with

Married with

Divorced since

Widowed since

**Do you have children?** No / Yes

Yes, living at home how many: date of birth:

Yes, moved out how many: date of birth:

**Profession**

I work as: …….....

Unemployed since ..... ; I used to be: .......

Incapacitated since ....... ; I used to be: ........

I study ..........................................................

**Transfer data/medical information for good health care and research**

Do you give us permission to make your patient file accessible to other doctors (such as emergency care professionals, like *[name SEH -vul in]* in order to improve your health care in emergency situations by using the infrastructure for care sector communication (LSP)? For more information please visit [www.vzvz.nl](http://www.vzvz.nl)). Permission: Yes / No

**Signature:**

We participate in scientific research by NIVEL. Your data about diseases, use of medicines and referrals are processed completely anonymously. Employees of NIVEL cannot trace back the information to individual patients. See their privacy policy on [www.nivel.nl](http://www.nivel.nl) Permission: Yes / No

**Signature:**

Do you give us permission to make important data accessible to pharmacists in order to improve the control of your medication by using LSP? Permission: Yes / No

**Signature:**

**Questions concerning your health situation**
Do you smoke ? No / yes: ……….cigarettes per day since ……………….

Do you drink alcohol? No / yes: ……….glasses of …………………. a day (average)

Do you use drugs? No / yes: ……………….

Did you ever measure your blood pressure? No / Yes, it was: ………….. (when?)……………

Do you get a flu (influenza) vaccination every year because of medical reason(s)? No / yes, because of …………………

*Women*

Did you ever have a cervical / pap smear? No / yes in ….. (last)

Did you ever have a mammogram? No / yes in **.....**  (last)

**Are you known with health problems (or operations) now or in the past?**

Diabetes/ lungdisease (asthma, COPD)/ hypertension/ cardiovascular disease/ overworked/ depression or anxiety disorder/ eating disorder/ liver- or intestine disease/ thyroid condition/ articulation disease / STDs/ other severe disease?

*Are you being treated by a specialist?*

No

Yes, medical specialty ......... because of .......

Yes, medical specialty …….. because of ......

*Do you use medication?*

No

Yes (please state which medication you use, the dosage and frequency of usage) ……………………………………………………………………………………………………………………………………………..

*Did you ever have a hepatitis B vaccination?* No / yes ………………. (when)

*Do you have allergies*? No / Yes

Specific medicine(s) ......

Food or drinks ......

Other allergies? .....

*Did you ever have a major accident or surgery?*

Accident .....

Surgery .....

Hospital stay .....

*Have you ever been a victim of (sexual) violence?* No / Yes

**Are there chronic illnesses in your family?**

Diabetes relative?

Hypertension relative?

Cardiovascular diseases relative?

Stroke /CVA relative?

Asthma/copd relative?

Kidney disease relative?

Psychic disease relative?

Cancer relative? What type of cancer? ……………………………..

Congenital disease relative?