Doz. Dr. Christopher Springer, MBA

FACHARZT FÜR UROLOGIE

Ordinationsgemeinschaft MED3
Hintzerstraße 10, 1030 Wien

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www.urologiepraxis.at
dr.springer@urologiepraxis.at

Ordinationszeiten:
Mittwoch 13:00 - 19:00
Freitag 10:00 - 15:00

PATIENT QUESTIONNAIRE

Last name:

First name:

Date of birth:

Social Security Number: **Insurance Comp.:**

Complementary Insurance:

Welcome to my private practice and thank you for choosing to consult me for your care.
A few minutes of your time carefully answering the following questions will help me more accuratly assess your problem.

Address:

City:

Phone:

E-Mail:

Allergies:

Medication:

Surgeries:

Do you have any of the the following conditions?

Diabetes	**YES**		**NO**	
Thyroid diseases	**YES**		**NO**	
Hypertension (High blood pressure)	**YES**		**NO**	
Incline to thrombosis or embolism	**YES**		**NO**	
Back pain or disc-related problems	**YES**		**NO**	
Is there a cumulative number of cancer afflictions in your family	**YES**		**NO**	
Have you ever had a colonoscopy	**YES**		**NO**	

Do you Smoke **YES** ___ **Cig./Day** ___ **NO** ___ **No, I stopped since** ___

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On which urological topic do you need consulting / treatment?

Checkup / early detection

Potency decrease

Unfulfilled desire for a child

Vasectomy

Incontinence

Bladder infection (zystitis)

Kindey ailment / Stones

Other:

Personal passphrase for disclosure

Date | **Signature**

Declaration of consent

For transferring your data to other physicians or medical institutions.

I consent that my attending physician is allowed to transfer personal data (insurance no., date of birth, address, diagnosis and related information) to other physicians or medical institutions in order to complete diagnostic findings.

I also consent that in case of a referral to other physicians or medical institutions my attending physician has the right to get access to the results and diagnostic findings.

You can withdraw from this declaration of consent at any time.

Date | **Siganture**