Dr. med. Jördis Hendricks
Fachärztin für Innere Medizin
Praxis für Prävention-Stressmedizin-Stoffwechsel

Brunsberg 2
22529 Hamburg
Tel: 040-46092092
E-Mail: praxis-jh@gmx.de

Thank you for entrusting me with your health.

I am available to offer my expertise on all health-related concerns.

The focus of my practice is on the prevention and treatment of stress-related illnesses such as autoimmune diseases, obesity, high blood pressure, metabolic disorders, digestive disorders, exhaustion syndromes, depression, chronic joint and/or back pain, sleep disorders, unfulfilled desire to have children, etc.

I would like to prepare as thoroughly as possible for your first visit and plan enough time for our conversation and the necessary examinations. However, I need your help for this and would therefore like to ask you to take some time and answer the following questions in this Medical History Form as precisely and comprehensively as possible.

If a question is not clear, leave it open for now.

Please send the completed and signed form **by email to**: praxis-jh@gmx.de
or by post to: Praxis Dr. Jördis Hendricks
Brunsberg 2
22529 Hamburg
Germany

My assistant will then contact you immediately and suggest an appointment.

Yours sincerely,
Dr. med. Jördis Hendricks

Personal Information

Surname: First Name:

Place of Birth: Date of Birth:

Street House Number:

Postal Code: Place of Residence:

Health Insurance:

E-Mail:

Mobile:

Weight (kg): Height (cm):

Professional and Private Life

You are employed ☐ as:

Pupil/Student ☐ Not employed ☐ Retired ☐

Are there any stresses in your daily (professional) life? ☐ No ☐ Yes, please specify:

Do you need a hearing aid? ☐

Do you exercise regularly (daily, weekly)? ☐

Which diseases are known in your family (parents, siblings, uncle, aunt)?

(Please tick as appropriate)

- Heart Disease ☐
- Heart Attack ☐
- High Blood Pressure ☐
- Diabetes ☐
- Autoimmune Diseases ☐
- Thyroid Diseases ☐
- Obesity ☐
- Depression ☐

Which diseases are known in your family (parents, siblings, uncle, aunt)?
(Please tick as appropriate)

- Colon Cancer ☐
- Breast Cancer ☐
- Prostate Cancer ☐
- Cancer, other ☐

What illnesses do you have? (Please tick as appropriate)

- None ☐
- Heart Disease ☐
- Heart Attack ☐
- High Blood Pressure ☐
- Diabetes ☐
- Autoimmune Diseases ☐
- Thyroid Diseases ☐
- Obesity ☐
- Depression ☐
- Stroke ☐
- Colon Cancer ☐
- Breast Cancer ☐
- Prostate Cancer ☐
- Cancer, other ☐
- Bleeding Tendency ☐
- Stomach Disease ☐
- High Cholesterol ☐
- Kidney Disease ☐
- Lung Disease ☐

What current symptoms do you have? (Please tick as appropriate)

- Dizziness ☐
- Headaches ☐
- Exhaustion / Constant Tiredness ☐
- Pain ☐
- Skin Eczema / Skin Redness ☐
- Flatulence / Feeling of Fullness ☐
- Constipation ☐
- Diarrhea ☐
- Food Cravings ☐
- Difficulty falling asleep and/or staying asleep ☐
- Heartburn ☐
- Stomach Pain ☐
- Hair Loss ☐
- Night Sweats ☐
- Difficulty Urinating ☐
- Difficulty Breathing / Shortness of Breath ☐

What operations have you had? (Please tick as appropriate)

- None ☐
- Breast Surgery ☐
- Uterine Surgery ☐
- Tonsil Surgery ☐
- Appendix Surgery ☐
- Hernia Surgery ☐
- Gall Bladder Surgery ☐

Do you take any medication regularly?

None ☐

If so, which ones?

Do you experience weight fluctuations?

Weight Gain ☐

Weight Loss ☐

Remuneration

The patient agrees to pay the fee for medical services in accordance with the applicable rates of the German Medical Fee Schedule (GOÄ), with the threshold values of the GOÄ being fully utilized. The compensation becomes due in accordance with § 12 GOÄ once the patient has been issued an appropriate invoice. The physician points out that reimbursement of the compensation by insurances and reimbursement agencies may not be fully guaranteed.
The patient acknowledges that the medical services for this specific treatment are not covered by statutory health insurance.

Data Protection

I consent to my data being saved and stored in this private practice in accordance with data protection regulations and for the intended purpose, provided this is necessary for sending this medical history form and processing it after its return to the private practice of Dr. med. Jördis Hendricks.

Date, Location **Signature**

I would love to know how you became aware of my practice:

Internet ☐ Recommendation ☐ Other ☐

Thank you very much!
Your questionnaire will now be processed and then I look forward to meeting you personally.