

**Medical History Questionnaire**

PLEASE COMPLETE IN BLOCK CAPITALS / \*Required field

\*Family Name ..... \*Name.....

\*Date of Birth ...../...../.....  male  female

\*Address .....

\*ZIP/ City .....

Home Phone ..... \*Mobile.....

\*Email .....@.....

\*Mothers Name .....

\*Fathers Name .....

Occupation .....

\*Does your child have any allergies? If yes, what are they? .....

.....

\*Health insurance ..... ( Standard model  Family doctors models)

\*Name, Family Name of your pediatrician.....

\*City of your pediatrician .....

\*Reason for your visit:  I have no pediatrician  Didn't get an appointment at my pediatrician Absence of pediatrician  Tourist Other: .....\*How did you hear about us?  Pediatrician  Friends  Permanence  Facebook  Internet Advertisement  Flyer  Street  Pharmacy  Health Insurance  Media

Other: .....

**Your details will be kept strictly confidential and subject to medical confidentiality**

I hereby declare that the information I have provided is correct and agree that my data or findings from my medical history, including X-rays or photographs, and their copies or reproductions, may be shared for the medical, legal and payment purposes of other medical persons, insurance companies, debt collection or prosecution agencies, or made available to them on request.

**Should I leave the practice while waiting with my child, I take over the responsibility for my child for the time outside the practice.**

\*Zürich, (Date) ..... \*Signature: .....