



in association with  VZP for Foreigners

Patient Information

To schedule your next immediate medical appointment

First Name: _____ **Last Name:** _____

Date of birth (DD/MM/YY): _____

Sex (M or F): _____ **Nationality:** _____

Recommended to us by:

- | | | |
|-----------------------|----------------------|------------------------------|
| - Other doctor | - Passing by | - Visit doctors office |
| - Our patient | - Polyclinic website | - Media, Newspaper, TV, etc. |
| - Polyclinic Brochure | - Internet | - Pharmacy |
| - University | - Company | |

Insurance company who recommended us: _____

Address in Czech Republic: _____

Email: _____

Home Telephone (Czech): _____

Work Telephone: _____

Insurance Carrier (I.D.): _____

A person who can be informed about the state of my health:

First and Last name: _____

Address: _____

Telephone: _____

A person who can look into my medical documentation and make copies or extracts:

First and Last name: _____

Address: _____

Telephone: _____

Date: _____ **Signature:** _____



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Patient Information

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First and Last name: _____

Reason to visit: _____

- hypertension
- diabetes
- thyroid
- asthma / lung disease
- renal disease
- anemia
- joint pain
- allergies
- infections
- headache
- psychiatric illness
- cancer
- heart disease
- epilepsy
- stroke / tie

Other conditions: _____

Family Illness: _____

Past Medical history hospitalizations: _____

Current medications: _____

Recent blood test, x-rays, etc.: _____

Smoker: Yes – No

Alcohol in take: Yes- occasionally - No