PEDIATRIC MEDICAL PRACTICE
DR. MED. ALEXANDER KRÖCKEL & DR. MED. CORINNA CIESLA
Schwarzwurzelstr. 52-54
12689 Berlin

Medical History Form

Please complete this medical history form in full. Your information helps us ensure the best possible care and medical treatment for your child. Naturally, all data will be treated with strict confidentiality.

CHILD'S INFORMATION

Last name:	First name:
Date of birth:	Place of birth:
Gender: ☐ male ☐ female	Home address:

CHILD'S MEDICAL HISTORY

Has your child already been seen by another pediatrician?

☐ Yes ☐ No (If yes, please explain the reason for switching pediatricians)

Is this your first child?

☐ Yes ☐ No (If not, please indicate the number of other children.)

Was the pregnancy free of complications?

☐ Yes ☐ No (If no, please provide details.)

Were there any complications during birth?

☐ Yes ☐ No (If yes, please provide details.)

Has your child ever been treated or had surgery in a hospital?

☐ Yes ☐ No (If yes, why and when?)

Does your child have any allergies and/or intolerances? (e.g. food, medication)

☐ Yes ☐ No (If yes, which ones?)

Are there any illnesses or chronic conditions?

☐ Yes ☐ No (If yes, which ones?)

Does your child take any medications regularly?

☐ Yes ☐ No (If yes, which ones?)

Have all recommended vaccinations been administered? (according to STIKO guidelines)

☐ Yes ☐ No

INFORMATION ABOUT THE PARENTS

Mother of the child:

Full name:	Nationality:
Date of birth:	E-Mail:
Occupation:	Phone number:

Father of the child:

Full name:	Nationality:
Date of birth:	E-Mail:
Occupation:	Phone number:

Are there any illnesses or chronic conditions in the family? (e.g. diabetes, asthma, cancer, etc.)

☐ Yes ☐ No (If yes, which ones?)

Does anyone smoke in your home or near your child?

☐ Yes ☐ No

Consent Declaration:
If you do not attend a scheduled preventive check-up appointment and fail to cancel at least 24 hours in advance, we reserve the right to charge a **cancellation fee of €25**. We can offer you a maximum of three appointments. If the last appointment is also missed, no further appointments will be scheduled.

At our practice, we only accept patients whose children are vaccinated according to the current recommendations of the STIKO (Standing Committee on Vaccination). By signing below, we acknowledge and agree to this.

Place and date

Signature of the legal guardian(s):