1. Would you inform your previous General Practitioner that you registered at GP practice Van Heerde? And request them to send your medical records to us?
2. Bring the completed form together with a copy of your ID and copy of your insurance to the practice, or scan and mail the documents to the secure e-mail address of the assistant. This is the e -mail which is used to send you these forms.
3. **Personal details**

|  |  |
| --- | --- |
| Name: | Address: |
| Initial(s): | Postal code: |
| First Name: | Phone number (mobile): |
| Male/Female: | Phone number (fixed): |
| Date of Birth: | Phone number (work): |
| Country of Birth: | Email address: |
| Residing in The Netherlands since: | Name of new pharmacy: |
| Contact person/Representative: |  |

**Details previous General Practitioner**

|  |  |
| --- | --- |
| Name previous General Practitioner: |  |
| City: |  |
| Phone number: |  |

**Family or current living situation**

|  |  |
| --- | --- |
| ☐ Living alone | ☐ Married |
| ☐ Living together with: | ☐ Divorced since: |
| ☐ Roommate of: | ☐ Widow/widower since: |

**Do you have children? (Please fill in a separate form for every child living at home)**

|  |  |
| --- | --- |
| ☐ No |  |
| ☐ Yes, living at home | ☐ Number: |
| ☐ Yes, not living at home | ☐ Number: |

**Work / Education**

|  |  |
| --- | --- |
| ☐ I am studying |  |
| ☐ Completed school / education: |  |
| ☐ I am working, as a(n): | Employer: |
| ☐ I am on welfare |  |

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|  |  |
| --- | --- |
| Do you have a specific belief/religion? | If yes, which one? |
| Do you have hobbies? | If yes, which one? |
| Do you exercise/play sports? | If yes, which one? |

**Health and diseases. Are you currently under treatment by a medical specialist?**

|  |  |
| --- | --- |
| ☐ No |  |
| ☐ Yes, namely: |  |

**Have you ever had symptoms/manifestations of:**

|  |  |
| --- | --- |
| ☐ Diabetes | ☐ Anxiety |
| ☐ Lung diseases (Asthma, Chronic bronchitis, Tuberculosis) | ☐ Eating Disorders |
| ☐ Hypertension (high blood pressure) | ☐ Liver/bowel diseases |
| ☐ Cardiovascular diseases | ☐ Stomach diseases |
| ☐ Burn out | ☐ Thyroid diseases |
| ☐ Depression | ☐ Long-term joint problems |
| ☐Venereal diseases / STD | ☐ Other diseases:  |

**Do you use medication?**

|  |  |
| --- | --- |
| ☐ No |  |
| ☐ Yes, namely: |  |

**Are you allergic to certain medication?**

|  |  |
| --- | --- |
| ☐ No |  |
| ☐ Yes, namely: |  |

**Have you ever experienced side effects of certain medication?**

|  |  |
| --- | --- |
| ☐ No |  |
| ☐ Yes, namely: |  |

**Do you have any allergies?**

|  |  |
| --- | --- |
| ☐ Certain foods or drinks | If yes, which one(s): |
| ☐ Other nutrients | If yes, which one(s): |

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**Have you ever been in a major accident or have you ever had surgery/medical interference?**

|  |  |
| --- | --- |
| ☐ No |  |
| ☐ Yes, namely: |  |

**Lifestyle**

|  |  |  |  |
| --- | --- | --- | --- |
| Do you smoke? | No/ Yes | Number of cigarettes per day: |  |
| Do you drink alcohol? | No/ Yes | Number of glasses per day: |  |
| Do you use drugs? | No/ Yes | Kind of drugs/amount and quantity of use: |  |

**Has there ever been an HIV test performed on you?**

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ No |  |  |  |
| ☐ Yes |  | When: | Result: |

**Have you ever been a victim of sexual violence?**

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ No |  |  |  |
| ☐ Yes |  |  |  |

**Diseases running in the family**

|  |  |
| --- | --- |
| ☐ Diabetes | ☐ Asthma, Chronic bronchitis, |
| ☐ Hypertension (high blood pressure) | ☐ Kidney diseases |
| ☐ Cardiovascular diseases | ☐ Mental illness |
| ☐ Stroke or cerebral hemorrhage | ☐ Cancer, which type: |

**Is there any information not been asked, that you consider important for your General Practitioner to know?**

|  |
| --- |
| **PERMISSION TO SHARE MEDICAL INFORMATION WITH THE GP EMERGENCY POST****(EVENING AND WEEKENDS)****DO YOU GIVE PERMISSION?****YES** **NO** **Information:** <https://www.whiteboxsystems.nl/faq> |

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**DECLARATION of APPLICATION at a GENERAL PRACTITIONER**

**The undersigned**

|  |  |
| --- | --- |
| Name:  |  |
| Address:  |  |
| Postal code:  |  |
| Place of residence:  |  |
| Date of Birth:  |  |
| Health insurance provider: | Insured number: |

Hereby declares that he/she, as of \_\_\_-\_\_\_-\_\_\_\_\_\_(dd-mm-yyyy),

has been registered as a patient at:

GP practice Van Heerde

de Tourton Bruynsstraat 9

1063 XL Amsterdam

AGB-code praktijk 01053513

And the patient hereby gives permission to request the medical records at the previous General Practitioner.

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_-\_\_\_-\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Concerning the following person(s):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Name | Date of Birth | M/F | Health insurance provider | Insured number |
| 1 |  |  |  |  |  |
| 2 |  |  |  |  |  |
| 3 |  |  |  |  |  |
| 4 |  |  |  |  |  |
| 5 |  |  |  |  |  |
| 6 |  |  |  |  |  |
| 7 |  |  |  |  |  |
| 8 |  |  |  |  |  |

*Important note: This is the official declaration of application. We use this declaration as proof of your registration at this GP practice for the health insurance provider.*

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