

Please fill in before your appointment and hand it over at the rezeption!

Patient: _____
 surname firstname date of birth

phone: _____ e-mail: _____

By providing your mobile phone number and/or e-mail, do you agree to be informed or reminded of your appointments in our Doctolib online appointment calendar? **YES** **NO**

your family doctor here: _____ your profession: _____

We ask you for the following information:

What kind of troubles do you have: _____

Since when: _____

▼ Important previous illnesses/ operations

Infectious diseases ? (hepatitis, tuberculosis or other) _____

Inner diseases ? (diabetes, cardiovascular diseases, diseases of thyroid, of gastrointestinal tract, gout, glaucom, cancer or other)

Previous operations: _____
When: _____

Allergies/ Allergic to medication? _____

Du you take any anticoagulant medication? yes no
(ASS 100/ Falithrom/ Lixiana/ Xarelto/ Eliquis/ Pradaxa/ Clopidogrel/ Godamed or similar?)

Other medication: _____

Current blood pressure? _____/_____

Date: _____ your signature: _____