Dear patient!

We would like to give you the best possible treatment. However, this is only possible if we have knowledge about your current state of health and your pre-excisting deseases and operations.

your Name:..... your Firstname: ..... your Birthday:.....

1. Do you have any history of:

High blood pressure (also if he is well put medikamentös)? O no O yes
Diabetes? O no O yes
Desease of the liver? O no O yes
Heart-, circulation- or lung-desease ? O no O yes
Desease of the digestive tract (stomach, bowel)? O no O yes
Desease of the bladder or kidneys? O no O yes
Do you smoke? If so, how much? _____ O no O yes
Do you have varicose veins? O no O yes
Did you previously have a thrombosis? O no O yes
Did you previously have a pulmonary embolism? O no O yes
Did you previously have an epilepsy or seizure? O no O yes
Do you have a history of these infections: O no O yes
Hepatitis B or C, HIV, Tbc?
Are other current infections known? O no O yes, which?
_____
Did you previosly have a cancerous disease? O no O yes, which?
_____

2. Any pregnancy in history? O no O yes, how many?

_____

3. Do you know of any relatives, suffering from cancer, especially breast cancer or abdominal cancer? Ono O yes
who,what?_____

4. Are there cardiac infarction, thrombosis or stroke among close relatives? O no O yes
who,what?_____
5. Have you ever had surgery? O no O yes,
what, when?
_____
6. Do you take any medication? O no O yes
If so, which ones?

_____
7. Do you have any allergies? O no O yes
If so, which ones?

_____

Thank you for answering our questions! Date, Signature:_____