



Important information FOR YOUR DOCTOR

Current diseases

- | | |
|----------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Heart | <input type="checkbox"/> Vascular system |
| <input type="checkbox"/> Blood pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Stomach | <input type="checkbox"/> Lung |
| <input type="checkbox"/> Liver | <input type="checkbox"/> Nervous System |
| <input type="checkbox"/> Blood | <input type="checkbox"/> Infectious Disease |
| <input type="checkbox"/> Psychiatric Disease | <input type="checkbox"/> Other Organs |

Please mark the checkboxes if one of the following diseases has already been diagnosed.

Recent Symptoms/Conditions

Blood pressure

Do you have elevated blood pressure? Please write down your latest blood pressure values:

Date (Example)	Systolic (120)	Diastolic (80)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Glucose

Do you suffer from Diabetes mellitus? Please write down your latest blood glucose values:

Date (Example)	Mmol/L (100)	Mg/DL (5,56)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Cholesterol

Do you know your Cholesterol levels? Please write down your latest lab results:

Total cholesterol	mg/dl
<input type="text"/>	<input type="text"/>
HDL level	mg/dl
<input type="text"/>	<input type="text"/>
LDL level	mg/dl
<input type="text"/>	<input type="text"/>
Triglycerides	mg/dl
<input type="text"/>	<input type="text"/>





Smoking

I do not smoke I smoke _____ (No.) cigarettes a day

Drugs/Medication

Name	Dose	I take this drug	Side Effects/Comments
		<input type="checkbox"/> daily <input type="checkbox"/> from time to time	
		<input type="checkbox"/> daily <input type="checkbox"/> from time to time	

Which further burdens/conditions are you currently subjected to?

Stress Trouble (e.g. at work/with partner) Lack of Sleep

Family History

Did any of your parents, any of your brothers or sisters, or any of your children suffer from a heart attack?

Pain

Where does it hurt? (Please mark here ►)

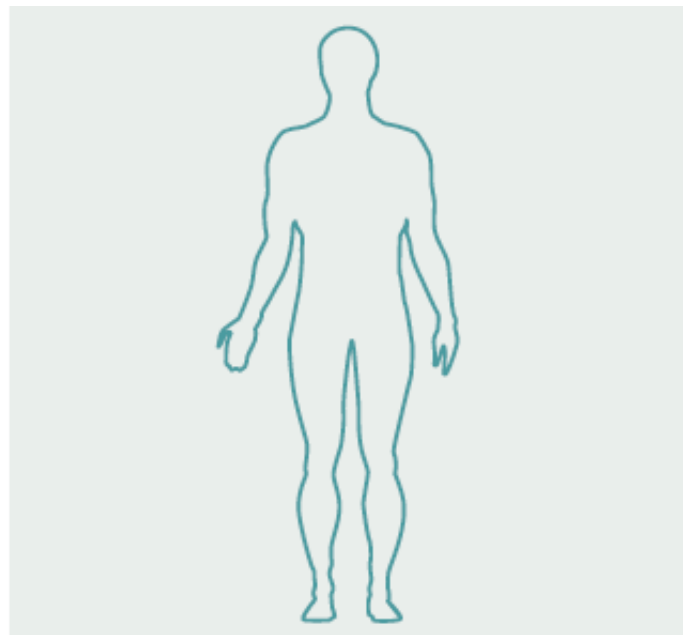
How often do you have pain?

- always
- very often
- from time to time

What makes it better?

What makes it worse?

Do you have other symptoms, such as chills or sweating?



Gastrointestinal Problems

Do you have any gastrointestinal problems?

Questions

Do you have questions? Please note them here and bring this form to your next appointment.

