

PATIENT DATASHEET FROM Ordination Dr. med. Eglseer

Title: surname and first name of the PATIENT

Date of birth: Gender: m / f

Postcode: City: Street:

Employer and place of employment of the insured

If you are not insured yourself:

Title: surname and first name of the INSURED:

Date of birth: Gender: m / f

Postcode: City: Street:

Relationship to the insured:

Telephone number: private work email

Occupation: Type of employment:

Marital status: Family doctor: Other physicians who regularly use you

Family diseases

Diseases of the father:

Diseases of the mother:

Father died with: years at: mother died with: years at:

Diseases in the relationship: Which disease? How related to you?

heart disease:

high blood pressure:

stroke:

diabete:s

Lipid metabolism disorders:

Cancer (which?):

mental illness:

Other common diseases:

Nicotine? I have never smoked

I smoked up to weeks / months / years to cigarettes / cigars / pipes per day / week - in total I smoked for years

I have been smoking cigarettes / cigars / pipes per day / week for years

Alcohol? Beer per day / week / month of wine per day / week / month

Most per day / week / month Schnapps (liquor) per day / week / month

Do you take or regularly take other addictive substances? If so, confidently contact your doctor. He is subject to strict medical confidentiality.

Allergies? Drug allergies:

Other allergies:

Previous hospitalizations or serious illnesses

When? Year Hospital / Location / Doctor Department Type of disease? Surgery? Detailed description

Do you regularly take medication?

exact name of the drug	dose in mg	early	noon	evening	If required

With my signature, I confirm the completeness and accuracy of my information!

Date: signature:

Room for other comments (to be filled out by the doctor):

li. OE: mmHg, Weight:

re. OE: mmHg, Size:

Pulse: /min.