Gemeinschaftspraxis für Kardiologie und Angiologie
Dres. C. Albrecht / S. Credner / J. Wilhelm/ C. Mergenthal / J. Kilian
Bad Homburg / Usingen / Königstein / Eschborn

Questionnaire about their disease History

Dear patient,
before being examined immediately, please answer the following questions about your medical history. This information is for further therapeutic and / or diagnostic recommendations very important. This questionnaire is part of your medical record:

Name:	**First name:**	**Date of birth:**
Size: **cm**	**Weight:** **kg**	**Profession:**
Phone number:	**Mobil number:**	

What are your complaints?

Which current doctor you care? Please specify if your payment has been issued by another doctor, or if no transfer occurs:

Name of Family-doctor:

What medication you take to time? **none↑**

Drug / Dose respectively strenght	In the morning	At midday	In the evening	In the night

What medication you are unable to tolerate? If so, What?

PLEASE ALSO COMPLETE THE NEXT PAGE →

Please list all important diseases or from etc past, eg Surgery, heart attack, cardiac catheterization, cardiac arrhythmias, stroke. If you or your family doctor to present medical reports, we would like to include them in the medical record.

Event	Which hospital, and date?

What are cardiac risk factors are known to you? Please mark:

High blood pressure yes □ no □	cholesterol increase □	uric acid increase □
High blood pressure for____ years	Smoking since: _____ Cigarettes per day: _____	Not smoking Possibly since: _____
excessive stress-strain in professional:□ in the Family:□	Movement- deficient □	Diabetes mellitus / Insulin □

What kind of heart disease in your family known: for example Heart attack, high blood pressure, cholesterol increases, diabetes, congenital heart disease, metabolic disease:

Family members (Father,Mother,Brother,Sister)	Diseas

Your health name of insurance?

Provide health insurance:

For statutory sickness insurance: is there a private supplementary insurance? Please tick the appropriate box: yes† no

If yes, name of insurance :_____

Privacy statement

I agree that my doctor / attending physician for the purpose of documentation and further treatment my findings and findings documents to my o.a. on-going (home) doctor forwards. My personal data is stored for at least 10 years. I understand that I may revoke this statement at any time in whole or in part for the future

_____ _____

Place/ date Signature of the Patient