Anamnesebogen

Dokument

complete Name, Date of birth	Profession (actual resp. previous)

Telefone	Email	Fax

Family doctor

I agree to disclosure of my personal data to the following persons / institutions *(mandatory to answer!)*:

☐ **to the laboratoris commissioned by the practice *(without your agreement no lab test can be performed!)***

☐ **Your family doctor mentioned above / ☐ The referring doctor**

☐ **Your other doctors (*name / adress*)** _____

☐ **family members (*please give name and date of birth*)** _____

☐ **I refuse any disclosure of my personal data to third persons.**

☐ **I agree to receive my results unencrypted by Email or Fax.**

This declaration of acceptance may be withdrawn by you at any time.

Did you have a colonoscopy previously? ☐ **No** ☐ **Yes, Year of examination: …….**

Have your vaccinations been actualized recently? ☐ **Yes** ☐ **No** **If "no", are you interested?** **Do you have a certificate of vaccination?** ☐ **Yes** ☐ **No**	☐ **Smoker?.....No of cigarettes daily** ☐ **Non-smoker?** ☐ **Ex-smoker?**	**Body weight: …… kg** **Body length: …… cm**

Please list the medical drugs which you take (permanently or on demand)

Name	Dosage

Previous operations, hospitalizations and concomitant diseases (Diabetes, Hypertension, Glaucoma,…)

Do you have allergies - especially against medication? (for example antibiotics, contrast-medium)

Date, signature: