

F Anamnesebogen (engl.)

Kapitel 1.2.1

Please use print

Name	First name	Date of birth	
Street No.	Postcode	Place	Phone No

Own medical history

Allergy yes no _____

Coughing yes no _____

Sputum yes no _____

Smoker? yes no Quantity per day _____

Alcohol/Beer/Wine/ others ja nein Quantity per week (glasses):

Vaccinations Influenza Pneumonia Tetanus Diphtheria

Other Vaccinations: _____

Appetite normal moderate less since:

Height /Weight: _____ kg, _____ cm

Increase/decrease _____ kg within _____ Week(s)/Month(s)

Surgeries no kind/ year: _____

Other disorders: yes no kind: _____

General Practitioner Name: _____

Address: _____

DMP participation at the GP's?

Diab. type II, Diab. type I, Heart disease Asthma COPD

Medication: Dose:

In the morning at noon in the evening bedtime

F Anamnesebogen (engl.)

Kapitel 1.2.1

Please use print

For diabetics:

Diabetes since: _____, with insulin treatment since when: _____

With OAD(Oral Antidiabetic Agent = tablets)treatment since when: _____

Last HbA1c _____%

Recent instruction _____ Diabetes High Blood Pressure
Hypertension

Recent examination of your eyes _____

Retinopathia known yes no

Was there any treatment with laser? yes no

High BloodPressure(HBP): yes no if yes, present BP ____/____ mmHg

Family medical history

Who (Father/Mother/Brother/Sister...) _____

Diabetes yes no who: _____

Heart Attack yes no who: _____

Stroke yes no who: _____

Hypertension (HBP) yes no who: _____

Children: _____ Married/Single: _____

Profession: _____

I assure the accuracy of my information.

Date: _____ Signature: _____

To be completed by the doctor

BP left arm ____/____ mmHg, right arm ____/____ mmHg HF____, Height____ cm,
Weight____ kg BMI: ____

Myocardinfarction : _____

Heart-Arrhythmics: _____

Angina pectoris: _____

Stroke: _____

Claudicatio: _____

Gastrointestinal Ulcers: _____

Intestinal Diseases: _____

Galle-Blader: _____

Thyreoid-Gland: _____

Asthma/COPD: _____

Cholesterol-Dysfunction: _____

Renal-Dysfunction: _____

Hypertension: _____

Addits: _____

Vaccinations _____