

MEDICAL INFORMATION

Have you ever suffered any of these diseases? If yes, please note date and diagnosis ¹

- Diabetes
- Lung diseases
- High blood pressure
- Heart disease
- Depressions
- Liver or intestinal diseases
- Eating disorder
- Sustained pain in the joints
- Venereal diseases
- Thyroid diseases
- None of the above

Are you presently being treated by a specialist? If yes, please note date and diagnosis:

- No
- Yes: a)
- b)

Are you presently on medication:

- No
- Yes:

Are you allergic tot:

- Certain types of medication:.....
- Certain foods or drinks:.....
- Other substances:
- Not allergic

Did you have a flu-vaccination during the past year:

- Yes, because:
- No

Have you ever suffered an accident and/or had an operation and if yes, please explain what and when:

- Yes:.....
- No

Do you smoke?

- Yes, cigarettes per day during ... years
- No

Do you drink alcohol?

- Yes, on average ... drinks per day
- No

Diseases running in the family, if yes, what family members (only first and second grade):

- Diabetes
- High blood pressure
- Heart disease < 60 years
- Cancer < 50 years
- Other diseases
- None of the above

Any other information that could be important for the doctor:

¹ Please check