CCB HERZ GEFÄSSE RHYTHMUS

PATIENT DATA:

Name, First Name

Address

Date of birth	Health insurance

ANGIOLOGY ANAMNESTIC SHEET

Phone number:______________________ Body height:__________cm Body weight:__________kg

So as not to forget an important point in the subsequent investigation, we ask you for your help and for the answers to the following questions:

Please describe your complaints:

____

____

How far can you walk without discomfort?__________m When do you have to stop?__________m

History:

Diabetes ◯	Thyroid disease ◯		Coronary heart disease/heart attack ◯	
Kidney disease ◯	Blood disorder ◯	Apoplexy ◯	Pulmonary embolism ◯	Thrombosis ◯
High blood pressure ◯	Increased cholesterol values ◯		Allergies:__________ ◯	

Smoking (history) no ◯ yes ◯ Since when & how many? ______________________

Have you ever had surgery on the vessels or been treated with a catheter? yes ◯ no ◯

If yes:____

Medication plan:

Do you take **medication regularly**? If yes, which one?______________________

____

Special medication that change blood clotting:

ASS ◯	Clopidogrel (Plavix®) ◯	Brilique® ◯	Efient® ◯	Marcumar® ◯
	Eliquis® ◯	Lixiana® ◯	Pradaxa® ◯	Xarelto® ◯

Other:

Would you like to point out a **special feature**?______________________

____

Reffering doctor (family doctor):

Name:____

Insurance data:

Stationary supplementary insurance:______________________ yes ◯ no ◯

For	1-Bed-Room ◯	2-Bed-Room ◯	Medical service ◯

Date:______________________ Patient signature:______________________

Patient data:

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VOLUNTARY CONSENT TO DATA PROCESSING

Dear Patient, Dear Patient,
as we take the subject of data protection very seriously in our practice, we would like to ask you to inform us of your wishes regarding the handling of your personal data. Should you have any questions, please do not hesitate to contact our staff. (First and last name - **please fill in in block capitals**):

___

I hereby agree that the following data processing operations may be carried out with my data.
I can revoke this consent at any time in parts and completely, informally and free of charge.

Permitted	Not permitted	
○	○	My relatives (spouse/life partner, children, acquaintances, etc.) may be informed about my current illness if I am unable to provide them with information myself. **Please provide appropriate names:** ___
○	○	My patient data may be stored beyond the legal retention period. After the legal retention period has expired, I may request deletion at any time.
○	○	My patient data may be forwarded to the person providing further treatment (e.g. specialist, general practitioner) be forwarded.
○	○	In case of inpatient admission to Bethanien Hospital or St. Mark's Hospital, I agree with the Data transfer to the corresponding hospital.
○	○	The CCB participates in medical studies. My data and possible residual samples from me may be used in the laboratory for scientific purposes.

Place, data:___________________________ Signature:___________________________