CCB HERZ GEFÄSSE RHYTHMUS

PATIENT DATA

Name, First Name:		
Address:		
Date of birth:	Health insurance:	
Phone number:	Body height: cm	Body weight: kg

ANAMNESTIC SHEET

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:

_____

_____

_____

Pre-existing medical condition/Risk factors:

Diabetes ◯	Thyroid disease ◯	Coronary heart disease/heart attack ◯	
Peripheral artery disease (PAD) ◯	Kidney disease ◯	Apoplexy ◯	Pulmonary embolism ◯
Increased cholesterol values ◯	Thrombosis ◯	High blood pressure ◯	Nicotine ◯
Allergies: ◯	Infectious diseases:	Hepatitis ◯	HIV ◯

Medication plan:

Do you take **medication regularly**? If yes, which one? See nationwide standardized medication plan ◯

_____

Special medication that change blood clotting:

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

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:_____