

Medical history

Coagulopathies:	<input type="checkbox"/> yes <input type="checkbox"/> no
Anaemia:	<input type="checkbox"/> yes <input type="checkbox"/> no
Myocardial infarction:	<input type="checkbox"/> yes <input type="checkbox"/> no
Angina pectoris:	<input type="checkbox"/> yes <input type="checkbox"/> no
Congenital heart diseases:	<input type="checkbox"/> yes <input type="checkbox"/> no
Diseases of the heart valves:	<input type="checkbox"/> yes <input type="checkbox"/> no
Arterial hypertension:	<input type="checkbox"/> yes <input type="checkbox"/> no
Heart arrhythmia:	<input type="checkbox"/> yes <input type="checkbox"/> no
Heart failure:	<input type="checkbox"/> yes <input type="checkbox"/> no
Cystic fibrosis:	<input type="checkbox"/> yes <input type="checkbox"/> no
Pulmonary insufficiency (serious):	<input type="checkbox"/> yes <input type="checkbox"/> no
Asthma:	<input type="checkbox"/> yes <input type="checkbox"/> no
Renal insufficiency:	<input type="checkbox"/> yes <input type="checkbox"/> no
Nephrolithiasis:	<input type="checkbox"/> yes <input type="checkbox"/> no
Hepatic insufficiency:	<input type="checkbox"/> yes <input type="checkbox"/> no
Gastric or duodenal ulcera:	<input type="checkbox"/> yes <input type="checkbox"/> no
WIPPLE-disease:	<input type="checkbox"/> yes <input type="checkbox"/> no
Diabetes:	<input type="checkbox"/> yes <input type="checkbox"/> no
Leukaemia:	<input type="checkbox"/> yes <input type="checkbox"/> no
Hypothyroidism:	<input type="checkbox"/> yes <input type="checkbox"/> no
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Multiple sclerosis:	<input type="checkbox"/> yes <input type="checkbox"/> no
Poliomyelitis:	<input type="checkbox"/> yes <input type="checkbox"/> no
Epilepsy:	<input type="checkbox"/> yes <input type="checkbox"/> no
Cerebral handicap:	<input type="checkbox"/> yes <input type="checkbox"/> no
Muscle dystrophia:	<input type="checkbox"/> yes <input type="checkbox"/> no
Myasthenia:	<input type="checkbox"/> yes <input type="checkbox"/> no
Diseases of the spinal cord:	<input type="checkbox"/> yes <input type="checkbox"/> no
Buccal tumor or deformation:	<input type="checkbox"/> yes <input type="checkbox"/> no
Larynx tumour:	<input type="checkbox"/> yes <input type="checkbox"/> no
Deafness (deaf):	<input type="checkbox"/> yes <input type="checkbox"/> no
Blindness (blind):	<input type="checkbox"/> yes <input type="checkbox"/> no
One-eyed:	<input type="checkbox"/> yes <input type="checkbox"/> no
Muteness (dumb):	<input type="checkbox"/> yes <input type="checkbox"/> no
Glaucoma (ocular hypertension):	<input type="checkbox"/> yes <input type="checkbox"/> no
Prostate, prostatitis:	<input type="checkbox"/> yes <input type="checkbox"/> no
Malaria:	<input type="checkbox"/> yes <input type="checkbox"/> no
Viral hepatitis:	<input type="checkbox"/> yes <input type="checkbox"/> no
AIDS:	<input type="checkbox"/> yes <input type="checkbox"/> no
Tuberculosis:	<input type="checkbox"/> yes <input type="checkbox"/> no
Other disease:	

Dependencie(s)

Tobacco:	<input type="checkbox"/> yes <input type="checkbox"/> no	Other:
Alcohol:	<input type="checkbox"/> yes <input type="checkbox"/> no
Coffee:	<input type="checkbox"/> yes <input type="checkbox"/> no

Surgical history

Brain surgery:	<input type="checkbox"/> yes <input type="checkbox"/> no	→ Congenital disease surgery:	<input type="checkbox"/> yes <input type="checkbox"/> no
Brain tumour:	<input type="checkbox"/> yes <input type="checkbox"/> no	Carotid obstruction:	<input type="checkbox"/> yes <input type="checkbox"/> no
Cerebral aneurysm:	<input type="checkbox"/> yes <input type="checkbox"/> no	Coronary "Stent":	<input type="checkbox"/> yes <input type="checkbox"/> no
Cerebral injury:	<input type="checkbox"/> yes <input type="checkbox"/> no	Coronary dilatation:	<input type="checkbox"/> yes <input type="checkbox"/> no
Cerebral haemorrhage:	<input type="checkbox"/> yes <input type="checkbox"/> no	Partial pneumonectomy:	<input type="checkbox"/> yes <input type="checkbox"/> no
Coronary bypass:	<input type="checkbox"/> yes <input type="checkbox"/> no	Total pneumonectomy:	<input type="checkbox"/> yes <input type="checkbox"/> no
Cardiac graft:	<input type="checkbox"/> yes <input type="checkbox"/> no	Partial gastrectomy:	<input type="checkbox"/> yes <input type="checkbox"/> no
Heart valve plastic surgery:	<input type="checkbox"/> yes <input type="checkbox"/> no	Total gastrectomy:	<input type="checkbox"/> yes <input type="checkbox"/> no
Heart valve replacement:	<input type="checkbox"/> yes <input type="checkbox"/> no	Nephrectomy:	<input type="checkbox"/> yes <input type="checkbox"/> no

Surgical history ...

Cholecystectomy:	<input type="checkbox"/> yes <input type="checkbox"/> no	→ Morphine pump implant:	<input type="checkbox"/> yes <input type="checkbox"/> no
Thoracic aortic aneurysm:	<input type="checkbox"/> yes <input type="checkbox"/> no	Nerve stimulator implant:	<input type="checkbox"/> yes <input type="checkbox"/> no
Abdominal aortic aneurysm:	<input type="checkbox"/> yes <input type="checkbox"/> no	Brain ventricular drainage:	<input type="checkbox"/> yes <input type="checkbox"/> no
Abdominal aortic bifurcation:	<input type="checkbox"/> yes <input type="checkbox"/> no	Arteriovenous fistula:	<input type="checkbox"/> yes <input type="checkbox"/> no
Hysterectomy:	<input type="checkbox"/> yes <input type="checkbox"/> no	Splenectomy:	<input type="checkbox"/> yes <input type="checkbox"/> no
Cystectomy:	<input type="checkbox"/> yes <input type="checkbox"/> no	Cesarian section:	<input type="checkbox"/> yes <input type="checkbox"/> no
Appendectomy:	<input type="checkbox"/> yes <input type="checkbox"/> no	Liver transplant:	<input type="checkbox"/> yes <input type="checkbox"/> no
Colectomy:	<input type="checkbox"/> yes <input type="checkbox"/> no	Kidney transplant:	<input type="checkbox"/> yes <input type="checkbox"/> no
Duodenopancreatectomy:	<input type="checkbox"/> yes <input type="checkbox"/> no	Heart-lung transplant:	<input type="checkbox"/> yes <input type="checkbox"/> no
Bone tumour:	<input type="checkbox"/> yes <input type="checkbox"/> no	Member amputation:	<input type="checkbox"/> yes <input type="checkbox"/> no
Slipped disc:	<input type="checkbox"/> yes <input type="checkbox"/> no	(finger, hand, forearm, arm, toe, feet, leg, thigh)	
Fracture of the spinal column:	<input type="checkbox"/> yes <input type="checkbox"/> no	Other:	
Oesophageal tumour:	<input type="checkbox"/> yes <input type="checkbox"/> no	
Cataract:	<input type="checkbox"/> yes <input type="checkbox"/> no	
Heart pacemaker:	<input type="checkbox"/> yes <input type="checkbox"/> no	
Model of pacemaker:	

Current Drug treatment

Anticoagulants:	<input type="checkbox"/> yes <input type="checkbox"/> no	→ Insulin:	<input type="checkbox"/> yes <input type="checkbox"/> no
Thrombocyte aggregation inhibition:	<input type="checkbox"/> yes <input type="checkbox"/> no	Oral antidiabetics:	<input type="checkbox"/> yes <input type="checkbox"/> no
Antiarrhythmics:	<input type="checkbox"/> yes <input type="checkbox"/> no	Anti-ulcera:	<input type="checkbox"/> yes <input type="checkbox"/> no
Antihypertensives:	<input type="checkbox"/> yes <input type="checkbox"/> no	Morphine or morphine derivates:	<input type="checkbox"/> yes <input type="checkbox"/> no
Beta-blocker:	<input type="checkbox"/> yes <input type="checkbox"/> no	Antiphlogistics:	<input type="checkbox"/> yes <input type="checkbox"/> no
Digitalis:	<input type="checkbox"/> yes <input type="checkbox"/> no	Immunodepressants:	<input type="checkbox"/> yes <input type="checkbox"/> no
Nitrate derivates:	<input type="checkbox"/> yes <input type="checkbox"/> no	Antimyasthenics:	<input type="checkbox"/> yes <input type="checkbox"/> no
Bronchodilator:	<input type="checkbox"/> yes <input type="checkbox"/> no	Antabus (disulfiram):	<input type="checkbox"/> yes <input type="checkbox"/> no
Oxygen (intermittent/permanent):	<input type="checkbox"/> yes <input type="checkbox"/> no	Benzodiazepine derivates:	<input type="checkbox"/> yes <input type="checkbox"/> no
Tricyclic antidepressants:	<input type="checkbox"/> yes <input type="checkbox"/> no	Theophylline:	<input type="checkbox"/> yes <input type="checkbox"/> no
MAO inhibitors (thymetetica):	<input type="checkbox"/> yes <input type="checkbox"/> no	Lithium:	<input type="checkbox"/> yes <input type="checkbox"/> no
Antiepileptics:	<input type="checkbox"/> yes <input type="checkbox"/> no	Methadone:	<input type="checkbox"/> yes <input type="checkbox"/> no
Barbiturates:	<input type="checkbox"/> yes <input type="checkbox"/> no	Suprarenal hormones:	<input type="checkbox"/> yes <input type="checkbox"/> no
Cortisone or corticoids:	<input type="checkbox"/> yes <input type="checkbox"/> no	Hypophyseal hormones:	<input type="checkbox"/> yes <input type="checkbox"/> no
Thyroid hormones:	<input type="checkbox"/> yes <input type="checkbox"/> no	Actual medications:	
		

Current long term treatment

Radiotherapy for cancer:	<input type="checkbox"/> yes <input type="checkbox"/> no	→ Renal dialysis:	<input type="checkbox"/> yes <input type="checkbox"/> no
Cancer chemotherapy:	<input type="checkbox"/> yes <input type="checkbox"/> no	Other:	
Palliativ care:	<input type="checkbox"/> yes <input type="checkbox"/> no	
		

Vaccinations in order at folder's date

Tetanus:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→ Yellow fever:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diphtheria:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cholera:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whooping cough:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Typhoid fever:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poliomyelitis:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rabies:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicella:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Others:					
Measles:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Rubella:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Mumps:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Hepatitis A:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Hepatitis B:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Pneumococcus:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Meningococcus:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Hemophilus Influenzae:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

