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Anamnesis form

Please answer the questions as completely and accurately as possible!

Name:_____

Adress:_____

Postcode, City:_____

Phone number:_____ **Email:**_____

Family doctor:_____

What are your **symptoms** now? _____

_____

_____

_____

Do you have any **allergies?** ☐No ☐Yes, whatkind:_____

Do you **smoke** or have you been smoking before? ☐No ☐Yes, quantity:_____

Do you drink **alcohol**? ☐Never ☐Rarely ☐2-3 per week ☐4-7 per week

What **medications** are you taking?

_____

_____

_____

Do you have any previous **diseases**? _____

_____

_____

Which **operations** did you have?

_____

_____

How did you hear about us?

☐Family/Friends ☐Homepage ☐Google ☐Docfinder ☐other_____

Signature:_____ **Thank you!**