Personal anamnesis

Anamnesis is completed by the patient prior to examination or intervention:

Mobile phone number: _____

Personal physician: _____

Date of last visit: _____

Name and surname: _____

Date of birth: _____

Address: _____

Former diseases:

GI disease:	☐ no	☐ yes	Which one: _____
Urinary tract disease:	☐ no	☐ yes	Which one: _____
Neuro-psychiatrics:	☐ no	☐ yes	Which one: _____
Heart disease:	☐ no	☐ yes	Which one: _____
Lung disease:	☐ no	☐ yes	Which one: _____
Jaundice:	☐ no	☐ yes	Since when: _____ ☐ A ☐ B ☐ C ☐ other
Other:	☐ no	☐ yes	Which one: _____
Transfusion in last 6 months:	☐ no	☐ yes	
Bleeding during surgery:	☐ no	☐ yes	
Anemia:	☐ no	☐ yes	
Other:	☐ no	☐ yes	Which one: _____

Examination:

Complete ultrasound:	☐ no	☐ yes	When last: _____
Gastroscopy:	☐ no	☐ yes	When last: _____
Colonoscopy:	☐ no	☐ yes	When last: _____

Former surgeries:

Abdominal:	☐ no	☐ yes	Which: _____
Other:	☐ no	☐ yes	Which: _____

Medicines:

Current medicines you are receiving and doses: **Any anticoagulants medicines: ☐ no ☐ yes**

Medicine: _____ How often: _____ How much. _____

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Preventive:

Hepatitis B vaccination: ☐ no ☐ yes When: _____

Hepatitis A vaccination: ☐ no ☐ yes When last: _____

Last OB/GYN check up When : _____

Are you pregnant: ☐ no ☐ yes Are you breastfeeding ☐ no ☐ yes

Last urology checkup: When : _____

Eating habits:

Are you adjusting your weight? ☐ no ☐ yes How: _____

How much fluid you consume daily (in liters)? _____

Pampering:

Smoking cigarettes? ☐ no ☐ yes How many (per day): _____ How long (in years)?: _____

Drinking alcohol? ☐ no ☐ yes ☐ casual ☐ daily Alcohol type/brand? _____

Please bring with you:

- Letters of possible accompanying diseases (such as diabetes, antithrombotic therapy, other internists, etc.)

- This notice with answers, and the forms that we have attached to this notice.

Ten days before treatment in our clinic you will receive a sms message that will remind you of the date and time of the appointment.

In order to ensure the smooth operation of the work in accordance with the provisions of the Patients' Rights Act (RS, No. 55/2017) and the Rules on Procurement and Management of Waiting Lists and the Longest Allowable Waiting Periods (RS 3/2018) as well as the Rules on Compulsory Health Insurance, please kindly ask us to follow the following guidelines:

- Without giving reasons, the term can be canceled no later than 10 days before the implementation of the health service, only once within the same posting, and only within a posting with a degree of urgency, fast or regular
- Subsequent termination of the term is allowed only for your objective reasons, and you are obliged to notify the reason for the cancellation in writing. Objectives are reasons (unexpected hospitalization of a patient or a close family member that prevents the patient from coming to the appointment or delivery of a medical service; sudden illness, injury or health condition of a patient or a close family member that prevents the patient from coming to the appointment or delivery of a medical service; the death of a close family member.

If you do not arrive at a specific date or you will not cancel the term in accordance with the previous paragraph, we are obliged to delete you from the waiting list, and your referral will expire.

With your signature, you guarantee the truth of the above information and thus contribute to a more successful treatment. By signing, you also give consent (pursuant to the third and fourth paragraphs of Article 44 of the Patients' Rights Act) for the processing of their health and other personal data for the needs of medical care: Thank you very much.

Date and time: _____

Signature od patient or legal representative: _____

Signature of the doctor (who reviewed and accepted the medical history): _____