Medical history: I_____I_____I_____I_____

Own history: Last name First name Birth date Age

Are you aware of the following diseases or previous illnesses? Please mark with a cross and indicate the date, if applicable.

Desease	**Yes**	**No**	**If yes, when** (JJJJ/MM)**?**
Breast cancer			
Colorectlal cancer			
Thrombosis/pulmo. embolism			
Heart attack			
Stroke			
Diabetes mellitus			
Dyslipidemia			
Osteoporosis			

Have you already had the following examinations? Please mark with a cross and indicate the date, if applicable.

Examination	**Yes**	**No**	**If yes, when** (JJJJ/MM)**?**
Mammography			
Mammasonography			
Bone densitometry			
Internist/Family doc Check-up			
Vascular exam / Cardiolology			

Family history:

Do you have a family history of the following diseases? Please mark with a cross and indicate who in the family has the disease.

Desease	**Yes**	**No**	**If yes, who and at what age?**
Breast cancer			
Colorectal cancer			
Thrombosis/pulmo. embolism			
Heart attack			
Stroke			
Diabetes mellitus			
Dyslipidemia			
Osteoporosis			

Medication history:

Are you taking any medications? If yes, please list with dosage.

Medications	**Dosage**