DR. MARIE-ISABEL MURRAY

1. Patient Registration Form

I. Personal Details		Today's Date:	
Last Name:			
First Name:			
Date of Birth:		Gender:	
Height in cm or in:		Weight in kg or lbs:	
Marital Status:		Number of Children:	
Address:			
Zip Code, City:			
Occupation:			
Contact Details:	Phone #:		
	Work Phone #:		
	Email Address:		
II. Health Insurance			
	Private Health Insurance		
	Statutory Health Insurance with additional private insurance for the ambulant sector		
	Self-payment		
Name of Insurance Policy or Plan:			
Details of Insurance Plan & Number:			

2. Medical History Form

I. Reason for your Visit:			
General Check-up:			
Cardiovascular Check-up:			
Angiological Examination:			
Follow-up Visit of Known Condition:	Name of Condition:		
Other Reasons (please indicate):			
When was your Last Medical Check-up?			
II. Do you have any of the following symptoms?			
Chest Pain (Angina Pectoris)?	No	Yes	
Breathing problems?	No	Yes	
Irregular heart rhythm?	No	Yes	
Oedema in the legs?	No	Yes	
Pain in the leg while waking?	No	Yes	
III. Known Pre-Existing Conditions			
Allergies	No	Yes	Unknown
High Blood Pressure	No	Yes	Unknown
Diabetes Mellitus (Type 1 or 2)	No	Yes	Unknown
Smoking	No	Yes	Unknown
High Cholesterol/ Blood Lipid Increase	No	Yes	Unknown
Coronary Heart Disease	No	Yes	Unknown
Other Heart Disease (e.g. valvular)	No	Yes	Unknown
Cardia Arrhythmia	No	Yes	Unknown
Arterial Circulation Disorders of the Legs	No	Yes	Unknown
Stroke or TIA	No	Yes	Unknown
Vein Problems	No	Yes	Unknown
Asthma	No	Yes	Unknown

Chronic Bronchitis (COPD)	No Yes Unknown
Other Lung Disease	Explain:
Renal Failure	No Yes Unknown
Thyroid Disorder	Explain:
Gastrointestinal Diseases	No Yes Unknown
Neurological Disorders	No Yes Unknown
Spinal and Back Problems	No Yes Unknown
Have you ever had any operations or interventional treatments?	
Operation Types:	
Heart Catheter or Angioplasty:	

IV. Medication

Please tell us about all medications / ointments / sprays that you may be taking regularly, regardless of whether these have been prescribed or are over the counter.

(Note: If you have a medication plan with a QR code, we can scan your plan into our system)

Medication	Dosage	Morning	Mid-Day	Evening
1.				
2.				
3.				
4.				
5.				