

**MEDICAL RECORD**  
(All information is confidential)

No of medical record: \_\_\_\_\_

Country: \_\_\_\_\_

First Name: \_\_\_\_\_

Surname: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Blood type: \_\_\_\_\_

Residence address during the Summit: \_\_\_\_\_

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**1) History of medical problems: (mark with X and explain the details):**

1.1 Hypertension ( )

1.2 Hypotension ( )

1.3 Greasy glands ( )

1.4 Cardiac clot ( )

1.5 Angina Pectoris ( )

1.6 Asthma ( )

1.7 Cardiac problem ( ) specify: \_\_\_\_\_

1.8 High cholesterol ( )

1.9 Brain clot ( )

1.10 Anemia in brain ( )

1.11 Chronic disease in the respiration ( ) specify: \_\_\_\_\_

1.12 Epilepsy ( )

1.13 Any nervous or psychological problems( ) specify: \_\_\_\_\_

1.14 Any eye, nose, or ear diseases ( ) specify: \_\_\_\_\_

1.15 Diabetes ( ) - Do you use insulin? \_\_\_\_\_

1.16 Allergy of medicines ( ) which medicine/s? \_\_\_\_\_

1.17 Allergy of food ( ) which food/s? \_\_\_\_\_

1.18 Hepatitis ( )

1.19 Other hepatic diseases ( ) specify:  
\_\_\_\_\_

1.20 Digestion problems ( ) specify: \_\_\_\_\_

1.21 Surgical operations ( ) specify: \_\_\_\_\_

1.22 Blood vessels problems ( ) specify: \_\_\_\_\_

1.23 Gallstones ( )

1.24 Nephrolithiasis ( )

1.25 Kidney, urinary or prostate problems ( ) specify: \_\_\_\_\_

1.26 Gynaecian disease ( )

1.27 Anemia ( )

1.28 Abnormal bleeding ( )

1.29 Arteries problems ( )

1.30 Veins varicose ( )

1.31 Glands Problems ( )

1.32 Pancreas problems ( )

1.33 AIDS ( )

1.34 Other diseases ( )

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2) Regularly used medicines

NO	MEDICINES	POTION	TIMES	ALWAYS	SOMETIMES
1					
2					
3					
4					
5					
6					
7					
8					
9					

Will you be accompanied by a medical team?  Yes  No

Full Name: \_\_\_\_\_

Do you need any medical services? \_\_\_\_\_

Signature: \_\_\_\_\_