Please send the filled application form to the following service hotline emails:

Eastern customer service line:
asia.pacific@cbiotec.com

(Asia, Africa, Australia & Oceania)

Western customer service line:
euro.atlantic@cbiotec.com

(EU, North, Latin & South America, UK)

GENERAL HEALTH FORM

I. PERSONAL INFORMATION

FIRST NAME (S)	***LAST (FAMILY) NAME***	***BIRTHDATE***		
PROFESSION/OCCUPATION	***MARITAL STATUS***	***CHILDREN***	***HEIGHT***	***WEIGHT***
	Single Married Separated Divorced Widowed			

CONTACT DETAILS

ADDRESS	*CITY*	*STATE/PROV /*	*POSTAL CODE*	*COUNTRY*

PHONE/CELL	*E-MAIL*	*FAX*

VIBER WHATS UP WECHAT / TELEGRAM	***SOURCE OF INORMATION ABOUT THE CLINIC*** Other patient (friend, relative) Internet Clinic's Official Doctor Partner

	Other (please, specify)

II. MEDICAL INFORMATION

A. PAST HISTORY		
Please, answer the questions below:		Please, specify(dates, diseases, examinations, treatment)
1. Do you have health problems at present?	Yes No	
2. Have you ever lost your working capacity for more than 4 weeks over the last 5 years? 5 4	Yes No	
3. Hospitalizations and surgeries in the past	Yes No	
RESPIRATORY DISEASES (in the past, lately or chronic)		
Asthma	Yes No	
Chronic bronchitis	Yes No	
Pneumonia	Yes No	
Tuberculosis	Yes No	
Other	Yes No	
CARDIOVASCULAR DISEASES (in the past, lately or chronic)		
Hypertension	Yes No	
Stroke	Yes No	
Angina pectoris	Yes No	
Myocardial infarction	Yes No	

Cardiac malformations	Yes No	
Heart failure	Yes No	
Thrombosis	Yes No	
Arterial diseases	Yes No	
Other	Yes No	
MENTAL AND NEUROLOGIC DISORDERS (in the past, lately or chronic)		
Loss of consciousness	Yes No	
Epilepsy	Yes No	
Paralyses	Yes No	
Neuritis	Yes No	
Head injury	Yes No	
Attempted suicide	Yes No	
Other	Yes No	
GASTROINTESTINAL DISEASES (in the past, lately or chronic)		
Gastritis	Yes No	
Peptic ulcer	Yes No	
Liver diseases	Yes No	
Pancreatic diseases	Yes No	
Gall bladder diseases	Yes No	
Other	Yes No	
GENITOURINARY DISEASES (in the past, lately or chronic)		
Urolithiasis (kidney stones)	Yes No	
Cystitis	Yes No	
Pyelonephritis	Yes No	
Prostatitis	Yes No	
Adnexitis	Yes No	
Other	Yes No	
SKIN PROBLEMS (in the past, lately or chronic)		
Psoriasis	Yes No	
Dermatitis	Yes No	
Tumors	Yes No	
Other	Yes No	
MUSCULOSKELETAL DISEASES (in the past, lately or chronic)		
Bone diseases	Yes No	
Joint diseases	Yes No	
Spinal cord diseases	Yes No	
Disc hernia	Yes No	

Muscle diseases	Yes No	
Ligament problems	Yes No	
Tendon problems	Yes No	
Rheumatism	Yes No	
Injury	Yes No	
OPHTHALMOLOGIC (EYE) DISEASES (in the past, lately or chronic)		
Glaucoma	Yes No	
Cataract	Yes No	
Retinal diseases	Yes No	
Other	Yes No	
ENT DISEASES (in the past, lately or chronic)		
Otitis	Yes No	
Hearing loss	Yes No	
Sinusitis	Yes No	
Tonsillitis	Yes No	
Other	Yes No	
ENDOCRINE DISEASES (in the past, lately or chronic)		
Diabetes mellitus	Yes No	
Gout	Yes No	
Thyroid diseases	Yes No	
Adrenal diseases	Yes No	
Other	Yes No	
BLOOD DISEASES (in the past, lately or chronic)		
Anemia	Yes No	
Coagulation failure	Yes No	
Other	Yes No	
IMMUNE SYSTEM OR INFECTIOUS DISEASES (in the past, lately or chronic)		
Allergies	Yes No	
HIV/AIDS HIV	Yes No	
Viral hepatitis (B,C, E, F)	Yes No	
Other	Yes No	
OTHER DISEASES (in the past, lately or chronic)		
Tumors	Yes No	
Sexually transmitted diseases	Yes No	

Genetic diseases	Yes No	
Any other disease unlisted above	Yes No	
B. SYMPTOMS		
Do you presently experience the symptoms listed below?		Please, specify (dates, diseases, examinations, treatment)
1. Weight loss/gain /	Yes No	
2. Appetite changes	Yes No	
3 Fever, shivering	Yes No	
4. Urination problems	Yes No	
5. Dizziness	Yes No	
6. Eyesight problems	Yes No	
7. Loss of consciousness	Yes No	
8. Pain or discomfort in the abdomen	Yes No	
9. Digestion problems	Yes No	
10. Heartburn	Yes No	
11. Gas	Yes No	
12. Diarrhea or loose stool	Yes No	
13. Constipation	Yes No	
14. Sleep disorder	Yes No	
15. Mood swings	Yes No	
16. Stress	Yes No	
17. Depression	Yes No	
18. Anxiety	Yes No	
19. Fears	Yes No	
20. Stress caused by family or work problems	Yes No	
21. Sexual problems	Yes No	
22. Hearing problems	Yes No	
23. Swallowing problems	Yes No	
24. Cough	Yes No	
25. Blood in saliva/ sputum /	Yes No	
26. Breathing problems	Yes No	
27. Chest pain	Yes No	
28. Chest pressure	Yes No	
29. Chest discomfort	Yes No	
30. Pulse/cardiac rhythm disturbance /	Yes No	
31. Joint edema	Yes No	
32. Joint pain	Yes No	
33. Skin problems	Yes No	
34. Headache	Yes No	
35. Backache	Yes No	
36. Weakness, fatigue	Yes No	
37. Easy bruises	Yes No	
38. Gait problems	Yes No	
39. Breast pain	Yes No	
40. Breast hypersensitivity	Yes No	
41. Breast induration	Yes No	

42. Pelvic pain	Yes No	
43. Nausea	Yes No	
44. Vomiting	Yes No	
45. Pain and discomfort at urination	Yes No	

III. MALE / FEMALE PECULIARITIES /

FOR MEN ONLY		FOR WOMEN ONLY	
1. Do you feel that your urinary bladder is not totally empty after urination?	Yes No	1. Is your menstrual cycle regular?	Yes No
2. Do you feel a need to pass urine earlier than 2 hours after the last urination? 2	Yes No	2. Do you have children?	Yes No
3. Have you noticed that your urine stream has become weak?	Yes No	3. Premenstrual syndrome (lower abdominal pain, back pain, headache)	Yes No
4. How often do you need to strain in order to pass the urine?	Yes No		Yes No
5. Do you wake up at night to pass the urine?	Yes No	4. Abortions	Yes No
Do you have children? 6.	Yes No	5. Diagnostic curettage 6. Caesarean section	Yes No
7. Genitourinary infections over the last year	Yes No	7. Have you ever had urinary incontinence?	Yes No
8.Date of the latest urology Examination		8. Genitourinary infections within the last year	Yes No
		9. Date of the latest gynecological examination	

IV. LIFESTYLE AND HABITS

PHYSICAL LOAD	
Inactive (sedentary) lifestyle (hardly any exercise)	Yes No
Minimal physical activity (going upstairs, walking up to 3 bocks, golf) 3	Yes No
Irregular physical activity (physical work or exercising (active rest) max 4 times a week for 30 min.)	Yes No
Regular physical activity (physical work or exercising (active rest) 4 times a week for 30 min.)	Yes No
Other	

NUTRITION		
Regular diet	Halal	Kosher
Vegetarian	Vegan	Special diet not prescribed by the doctor
Special diet not prescribed by the doctor		(please, specify below)

BAD HABITS			
Alcohol		**Smoking**	
Do you drink alcohol?	Yes No	Do you smoke?	Yes No
How often do you drink alcohol and in what amounts?		If, yes, how many cigarettes do you smoke per day?	Yes No
Are you concerned about the amount of alcohol you drink?	Yes No	Have you tried to give up smoking?	Yes No
Do you have drinking bouts?	Yes No	**Drugs**	
		Have you ever tried any drugs?	Yes No

V. MENTAL HEALTH

Is stress a big problem for you?	Yes No
Do you panic when you are stressed?	Yes No
Do you feel depressed?	Yes No
Has your appetite changed?	Yes No
Do you cry often?	Yes No
Have you ever tried to commit suicide?	Yes No
Have you ever consulted psychotherapist for any reason?	Yes No

VI. TESTS AND TREATMENT

Have you ever been tested for HIV?	Yes No
Are you taking any specific medications prescribed by the doctor	Yes No (if yes, please, specify)
painkillers	Yes No
sleeping pills	Yes No
Tranquilizers	Yes No
other medicines	Yes No If yes, please, specify