STATEMENT BY THE TREATING PHYSICIAN

It must be completed by the Attending Physician.

PATIENT DATA

Name of the Insured: Date of Birth: dd / mm / yy

First name | Middle name | First surname | Second surname

Height: Weight: Abdominal Perimeter:

◯ Pies ◯ Inches ◯ Meters ◯ Kilos ◯ Libras ◯ Inches ◯ In centimeters

Hip Circumference: Do you use nicotine products? **YES** ◯ **NO** ◯

What type of nicotine product?: Amount per day?:

From: dd / mm / yy Until: dd / mm / yy

INFORMATION ON THE LAST 5 CONSULTATIONS

DATE	REASON FOR CONSULTATION	RESULT / TREATMENT	BLOOD PRESSURE

STATEMENT BY THE TREATING PHYSICIAN

ILLNESSES AND/OR INJURIES

Definitive diagnosis(es): _____

Date of diagnosis: dd / mm / yy

Results of laboratory studies performed for diagnosis and monitoring of diseases or injuries:

_____

_____

_____

Results of electrocardiogram or cardiovascular function tests performed for diagnosis and monitoring of diseases or injuries: _____

_____

_____

Results of imaging studies performed for diagnosis and monitoring of diseases or injuries:

_____

_____

_____

Results of pathology or cytology studies performed for diagnosis and monitoring of diseases or injuries: _____

_____

_____

TREATMENTS

◯ Medical treatment Name of the medicine: _____ Dosage: _____

◯ Surgical treatment Procedure details: _____

_____

_____

STATEMENT BY THE TREATING PHYSICIAN

Has the patient been hospitalized? **YES** ◯ **NO** ◯

DATE	DIAGNOSIS	CURRENT CONDITION

Has the patient consulted other doctors? **YES** ◯ **NO** ◯

NAME	REASON FOR CONSULTATION	DATE

Comments, risk factors, or additional diseases, their complications and prognosis:

DOCTOR'S DATA

Name: _____ Telephone: _____

First name _____ Middle name _____ First surname _____ Second surname _____

Address: _____ Email: _____

Signature: _____ Date: dd / mm / yy