Name, surname, title

Education (primary, secondary, higher, university)

School (name)……………………………………………………….year of accomplishment….......

 **Occupations**

 **In males including military services, in females including parental leave**

|  |  |  |
| --- | --- | --- |
| Years (from till) | Employer | Position |
|  |  |  |
|  |  |  |
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**Information on specific diseases in close relatives:** ischemic heart disease, cardiac infarct, stenocardia (angina pectoris), chronic lower extremity ischemia, brain stroke, arterial hypertension, diabetes mellitus, oncologic diseases, allergies, tuberculosis

**Mother:** year of birth, diseases

**Father**: year of birth, diseases

**Brothers, sisters**: year of birth, diseases

**Children**: year of birth, diseases

**Childhood diseases** (e.g. often tonsillitis, inflammation of the middle ear, scarlet fever, pneumonia, hepatitis)

Year: disease:

**Operations** (name, year):

**Injuries** (fractures, and so on)

**Medication (drugs)**:

**Allergies:**

I declare that I informed the occupational doctor of the Department of Occupational Medicine of General University Hospital in Prague on my health condition and did not conceal any information on my health state / diseases according to the Law No.372/2011 Sb. § 41 paragr. 1 letter d).

Date: Signature: