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| Name:  Vorname: |  | Geburtsdatum:  Datum: |  |
| Medikation: |  |  |  |
| Uhrzeit | Tätigkeit  z.B.: Schlaf, Spaziergang | Beschwerden z.B.: Schwindel, Herzstolpern, Schmerzen | Bedarfsmedikation |
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