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Medical History

Dear Patient,

Please fill in this form as completely as possible. This will help us to have an overview of your medical history and to coordinate your treatment accordingly.

Please ask us if you need help with filling in this form.

Last name/surname: First name:

Address:

Date of birth:

Height: ________________ cm Weight: ____________ kg

Current occupation: ____

Telephone: Land line: ____

Mobil/cell phone: _____________________________________

E-Mail: ____

Your GP (family doctor): ____

Gynecological history:

Peiod/menstruation: first period with ____________________ age
last period with ____________________ age

On what day did your last period begin? ____________________
Does your period come in regular intervalls? ________________
How many days is your complete menstrual cycle? ____________
How many days is your menstrual bleeding? ________________

When did you have your last gynecological cancer check?

When did you have your last mammogram?
(breast cancer check) ____

When did you have your last colonoscopy?
(examination oft he bowel for cancer and precancer growth) ___________________________

What are your current complaints for your visit here?

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Current contraceptive method:
e.g. contraceptive pill, contraceptive patch, vaginal ring, intrauterine device (IUD), contraceptive injecction, condom, sterilization, etc.

_______________________________ since ____________________________

Births:

Date	Birth method (spontaneous, c-section, vaccum extraction, forceps)	Sex oft he child	Complications

Miscarriages / terminations of pregnancy (abortions) / ectopic pregnancy:

Date	Miscarriage	Termination (abortion)	Ectopic pregnancy (please indicate if left or right)

Gynecological operations:

Date	Type of operation

Regular consumptions of: Nikotine (how many cigarettes per day?) ______________
Alcohol (how many glasses per day?) ______________

Allergies: ____

Do you have any other complaints or diseases? (e.g.: hypertension, diabetes, heart, liver, kidney, thyroid diseases)

Have you ever had a thrombosis or pulmonary embolism? ______________________

Current medication:

Other operations:

Date	Type of operation (e.g. appendectomy)

Serious health problems in your family:

Relationship (e.g. mother, brother, aunt)	Disease (e.g. cancer, hypertension, diabetes, blood clotting disorder, hereditary diseases)

______________________ ______________________
Date Signature