GANZHEITLICHE
FRAUENHEILKUNDE
DR. MED. C. SADOWSKI
DR. MED. A. KREKLAU*
*ANGESTELLTE ÄRZTIN

Medical History

Dear patients,

We welcome you to our practice. In order to be able to take full responsibility for your treatment, we ask you to answer the following questions carefully. Of course, all information is subject to medical confidentiality. Please confirm the completeness and accuracy of your information with your signature at the end of the document.

Personal details:

Surname, first name: _____ Date of birth: _____

Adress: _____

Marital status: _____ Profession: _____

E-Mail: _____ Phone number: _____

Family doctor (Name/Adress): _____

Height in cm: _____ Body weight in kg: _____

Gynecological information:

Age at 1st period: _____ 1st day of the last period: _____

How many days are between two periods: _____

My period bleeding is: ☐ normal ☐ weak ☐ strong ☐ painful ☐ irregular

Do you suffer from other period-related symptoms (e.g. headaches, sadness, upsets)? ☐ yes ☐ no

Last gynecological check-up: _____

Only for patients aged 50 and over: last mammogram: _____

last colonoscopy: _____

Do you have children: ☐ yes ☐ no Number of births: _____

Births:	Year	Normal delivery	Caesarean section	Forceps/Vacuum delivery
1.	_____	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
2.	_____	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
3.	_____	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
4.	_____	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no

Were there any complications during pregnancy or birth: ☐ yes ☐ no

If yes, which?: _____

Have you ever had:

Miscarriages: ☐ yes ☐ no How many: ____ Interruption: ☐ yes ☐ no How many: ____

Ectopic pregnancies: ☐ yes ☐ no How many: ____

Gynecological operations: ☐ yes ☐ no

If yes, which?: _____

Have you had an HPV vaccination?: ☐ yes ☐ no

Which contraceptive(s) are you currently using?

☐ Hormonal contraception (birh control pill, ring) name: _____

☐ Intrauterine device ☐ Condom ☐ Diaphragma ☐ Implanon ☐ Three-month injection ☐ Sterilization

☐ Natural procedures

Do you wish to use a contraceptive method? ☐ yes ☐ no

Do you currently want to have children? ☐ yes ☐ no

General Information:

Do you suffer or have you suffered from one of the listed illnesses? (Please check)

☐ high blood pressure	☐ Thyroid diseases	☐ Depression/Anxiety disorder
☐ Heart disease	☐ Kidney disease	☐ Eating disorder
☐ Thrombosis/embolism	☐ Metabolic diseases	☐ Hormone disorder
☐ Blood clotting disorder	☐ Asthma/COPD	☐ Endometriosis/fibroids
☐ Anaemia	☐ Osteoporosis	☐ Ovarian cysts
☐ Gastrointestinal disorder	☐ Migraine	☐ Menopausal symptoms
☐ Liver/Biliary disorder	☐ Epilepsy	☐ Acne/hair loss
☐ Diabetes	☐ Stroke	☐ Allergies: _____

☐ Cancer: _____

☐ Others: _____

What is your nutrition like? ☐ Whole food ☐ Vegetarian ☐ Vegan

Do you take medication regularly or occasionally? ☐ yes ☐ no

If yes, which ones (if applicable, medication plan)? _____

Do you take hormones? ☐ yes ☐ no

If yes, which ones and since when? _____

Do you smoke? ☐ yes ☐ no _____ Cigarettes per day

Do you drink alcohol or use drugs regularly? ☐ yes ☐ no

Have you had all your vaccinations updated? ☐ yes ☐ no (Please show us your vaccination certificate)

Do you have any history of cancer in your familiy (breast/ovarian cancer/other malignant diseases) or thrombosis, pulmonary embolism? ☐ yes ☐ no

If yes, which ones and with which family member? _____

Date: _____ **Signature:** _____