



## 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: \_\_\_\_\_

Address: \_\_\_\_\_

Marital status: \_\_\_\_\_ Profession: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Phone number: \_\_\_\_\_

Family doctor (Name/Address): \_\_\_\_\_

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: \_\_\_\_\_

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Gynecological operations:  yes  no

If yes, which?: \_\_\_\_\_

Have you had an HPV vaccination?:  yes  no

Which contraceptive(s) are you currently using?

Hormonal contraception (birth control pill, ring) name: \_\_\_\_\_

Intrauterine device  Condom  Diaphragm  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 disease  depressionen/anxiety disorder

heart disease  kidney disease  eating disorder

thrombosis/embolism  metabolic disease  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 family (breast/ovarian cancer/other malignant diseases) or thrombosis, pulmonary embolism?  yes  no

If yes, which ones and with which family member? \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

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