medical history

Dear patient,

please answer these questions calmly, which are essential for correct and good treatment. Please contact us if you need help filling out the form. All information is of course confidential.

surname, first name: _____

geb. am: _____

phone number: _____

mobil number: _____

Email:
please write clearly! _____

job activitiy: _____
marital status:
insurance: _____

familiy doctor: _____

_____

children?	year	weight	birth mode	m/f ?
miscarriages?	number?			

type of contraception:
(pill, IUP,
condome etc) _____

Hormone replacement therapy? _____

operations: _____
(z.B Uterus, Ovaries,
Appendix, Breast ,
Abdomen) _____

_____

familiy diseases:
(e.g. breast cancer,
ovarian cancer,
or colon cancer
or coagulation disorders,
thrombosis, strokes)

own
medication intake:
(which?

own diseases:
(e.g. high blood pressure,
Thyroid disease,
etc)

allergie to drugs:

first period (age?)

do you smoke-
if so, how many cigarettes?

menopause (age?)

height/ weight?

last gynecologist appointment
with check-up:
(with whom?)

mammography date:

coloskopy date?

how did you get from our
experience practice ?:

date, signature