FRAUEN
GESUNDHEIT

Dear Patient,

are you vaccinated against cervical cancer (HPV)?

O Yes ***O No*** ***O I`m not sure***

Surname, first name:

Birthday:

Phone Number Festnetz

Mobil

Email
(please write clearly)

job activity

marital status:

Insurance:

height cm weight kg

family doctor

age of first period? **age of the menopause?**

Have you had miscarriages?
O N0 O Yes (number/ year?)

type of contraception?
(z.B. pill, IUP, condome)

hormone replacement therapy? O No O Yes
(name?)

Have you got children?

	Year	Weight	male/ female	birth mode
1				
2				
3				

Own diseases or allergies?
(z.B. high blood pressure, thyroid disease?)

operations? O No O Yes (which?)

familiy diseases (e.g. breast cancer, ovarian cancer,

Coagulation disorders, thrombosis, strokes?)

Own medication intake? O No O Yes (which?)

do you smoke? O No O Yes

mammography date? O No O Yes (year?)

coloscopy date? O No O Yes (year?)

Last gynocologist appointment with check- up?

(year?)

Bad Soden, signature