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) _____

Adress: _____

marital status: _____

Insurance: _____

height ____ cm weight ____ kg

job activity: _____

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