

# Allgemeine Patientendaten Gynäkologie (englisch)

Nummer: FO-16586

Last Name	First Name	Date of Birth
_____		
Address		
_____		
Telephone and / or Mobile No.		
_____		
E-Mail-address	Nationality	
_____	_____	
Marital Status	Occupation	
_____	_____	

## Dear Patients,

In the interests of optimal medical care, we kindly ask you to answer the following questions.

Do you give the permission to report your case details back to your referring doctor?  yes  no

Name of your gynecologist: \_\_\_\_\_

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

Doctolib

Do you agree to appointment reminders by email + SMS sent via Doctolib?  yes  no

Do you agree to the transmission of documents via Doctolib?  yes  no

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

## What main complaints bring you here?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Last visit to the gynecologist: \_\_\_\_\_ Last cancer prevention (PAP-smear): \_\_\_\_\_

Gave you ever had	When?	Any abnormalities?
Mammography		
Bone Densitometry		
Colonoscopy		

**Vaccinations:** rubella/varicella/ whooping cough:  yes, when? \_\_\_\_\_  no

## General history

Please indicate whether you currently suffer or have ever suffered from any illnesses.

	No	Yes	What?	When?
Diseases of the cardiac or vascular system (e.g. hypertension)				
Diseases of the nervous system (e.g. migraine, stroke, epilepsy)				
Diseases of the lung				
Diseases of the liver, bile, pancreas				
Diseases of the gastrointestinal tract				
Diseases of the kidneys and urinary tract				
Metabolic disorders (e.g. thyroid disease, diabetes, high cholesterol)				
Cancer				
Mental illness				
Skin/Hair				
Bones				
Sexually transmitted diseases				
Other				

## Have you ever been operated on?

Surgery: what -why	Where	When

## Which medications, vitamins, minerals or natural healing products do you currently use?

Medication	from	to	Dose

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Do you currently take or have ever taken an "anti-baby pill" or a hormone replacement therapy?  yes  no

Name of the medication	Start of treatment	End of treatment	Reasons for ending the treatment

Do you suffer from any allergies?  yes  no  
If so, please list the critical substances: \_\_\_\_\_

How much alcohol do you drink per week/day? \_\_\_\_\_

How many cigarettes do you smoke per day / week? \_\_\_\_\_

Do you take sleeping pills, drugs or stimulants?  yes  no  
If so, please list the names of substances and frequency of use: \_\_\_\_\_

Do you exercise regularly?  yes  no  
Please describe frequency and type of activity: \_\_\_\_\_

**Nutrition:**  mixed cost  vegetarian  vegan  other:

**Height:** \_\_\_\_\_ cm **Weight:** \_\_\_\_\_ kg

**Max. weight (throughout your life)** \_\_\_\_\_ kg, when: \_\_\_\_\_ **Min. weight** \_\_\_\_\_ kg, when: \_\_\_\_\_

**Family history:**

Did any of your relatives suffer from certain illnesses such as coagulation disorders, thromboses, embolisms, heart attacks, strokes, blood clotting disorders, diabetes, high blood pressure, high blood lipid levels, and cancers?

Illness	Who	Age of onset

**Gynecological and obstetric history**

Age of the first period (menarche)? \_\_\_\_\_

Cycle length (onset of bleeding until the beginning of next bleeding): \_\_\_\_\_ days

Duration of period-bleeding \_\_\_\_\_ days

1st day of the last period: \_\_\_\_\_

Period bleeding:  light  medium  strong

Do you experience intermediate bleeding/spotting:  yes  no if so, since when?: \_\_\_\_\_

Menstrual pain:  yes  no When is the pain strongest?( \_\_\_\_\_ day of cycle): \_\_\_\_\_ Where? \_\_\_\_\_

Level of menstrual pain	1 (weak)	2	3	4	5	6	7	8	9	10 (strongest imaginable)

Do you experience any discomfort:

- While urinating? \_\_\_\_\_
  - During bowel movements? \_\_\_\_\_
  - During sexual intercourse? \_\_\_\_\_
- Any other discomforts/pain: \_\_\_\_\_

**Do you wish to have children?**

yes, I am currently trying to get pregnant.  
 yes, but at a later point in my life  
 no

For appr. \_\_\_\_\_ months  
In appr. \_\_\_\_\_ years

**Have you ever undergone fertility therapy?**  yes  no

When: \_\_\_\_\_ Why: \_\_\_\_\_ Successfully: \_\_\_\_\_

**Questions concerning your partner:** Age: \_\_\_\_\_ State of health: \_\_\_\_\_ No. of Children: \_\_\_\_\_ Status of spermogram: \_\_\_\_\_

**Have you ever been pregnant?**  yes  no

Number of pregnancies: \_\_\_\_\_ Number of births: \_\_\_\_\_

Year	Misscarriages	Abortos	Mode of birth

**Any complications/illness during pregnancy:**  Diabetes  high blood pressure  others: \_\_\_\_\_