endokrinologikum Berlin

General Patient data

Nummer: F0-16586

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 ofyour gynocolgist:_____

Do you want your test results/case reports sent by email: ☐ 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

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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				
Metabolie disorders (e.g. thyroid disease, diabetes, high cholesterol)				
Cancer				
Mental illness				
Skin/Hair				
Bones				
Sexually transmitted diseases				
Other				

Have you ever been operated an?

Surgery: what-why	Where	When

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

Meditation	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 oft 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 pill s, drugs or stimulants? ☐ yes ☐ no
If so, please list the names of substaces and frequency of use:_____
_____

Do you exercise regulary? ☐ yes ☐ no
Please describe frequency and type of activity:_____

Nutrition: ☐ mixed cost ☐ vegetarian ☐ vegan ☐ other:_____

Hight:_____cm Weight:____ kg

Max. weight (throughout your life)___ kg, when:___ _ **M in.** 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

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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 **D** medium ☐ strong

Do you experience intermediate bleeding/spotting: **D** yes **D** no if so, since when?:_____

Menstrual pain: **D** yes **D** 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:

1. While urinating? _____
2. During bowel movements? _____
3. During sexual intercourse?_____

Any other discomforts/pain:_____

Do you wish to have children?

Oyes, 1 am currently trying to get pregnant. For appr._____months
Oyes, but at a later point in my life In appr. years
Dno

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

When:_____Why:_____Successfully:_____

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

Number of pregnancies:____ Number of births:____ _

Year	**Misscarriages**	**Aborts**	**Mode of birth**

Any complications/illness during pregnancy: ☐ Diabetes ☐ high blood pressure ☐ others:_____

Questions concerning your partner:
Age:___ State of health:_____No. of Children:_____Status of spermiogram:_____