

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 of your gynecologist: _____

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**General Patient data**

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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				
Metabolic 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 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: _____ 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 medium strongDo 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?**O**yes, I am currently trying to get pregnant.

For appr. _____ months

Oyes, but at a later point in my life

In appr. _____ years

DnoHave 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 spermogram: _____