Formular

endokrinologikum Berlin

General Patient data

Nummer: FO-14701

Surname	First Name	Date of birth

Address

Phone no. (private) and/or mobile No. | Phone no. (work) | E-Mail

(Practiced) occupation

Weight ____ kg (changes?___) Height:____ cm

Do you smoke? ☐ No, since_____ ☐ Yes, ___ cig/day, for ____ years

How much alcohol do you drink per day?

Do you have any current complaints?

Do you currently suffer from an Illness - or have in the past (with year of initial diagnosis)?

Have you ever been subject to surgery (please add date)?

Which medications do you presently take (dosage)?

Allergies?

Women only:

Age at first menstruation? Years

Does your menstruation still occur? ☐ Yes ☐ No, ___ (age)

Is/was your cycle dependably regular, with normal bleeding strength and duration? ☐ Yes

No, I noticed _____

Number and year of pregnancies or miscarriages?

When was the first day of the last menstruation?

Do you take hormones (The „pill" or menopause hormones)? ☐ No ☐ Yes, _____

The referring doctor receives a medical letter	Agree:	☐ Yes	☐ No
Do you want to receive your report by e-mail?	Agree:	☐ Yes	☐ No

Date:_____ Signature:_____

The consent may be revoked without giving any reasons at any time.

Of course all information will be treated with strict confidentiality and serves information purposes exclusively.

Thank you