PROF. DR. MED.
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We care about your health.

All diseases can have a consequence to your treatment. Please fill this questionnaire very carefully.
It helps us treat you in the very best way. Of course, all given information is bound to professional discretion.

Personal Data

surname: _____

first name: _____

date of birth: _____

profession: _____

address: _____

_____

phone: private: _____

mobile: _____

email: _____

height: _____

weight: _____ **age:** _____

Health insurance

What is your state of health insurance?
○ private ○ compulsory

Insurance Company:

_____

Billing address, if different:

_____

_____

Are you eligible for government allowance?
○ yes ○ no

spoken languages:

_____

_____

Please answer the following questions

1. What brings you to us?

○ regular check-up
○ contraception
○ wish for a baby
○ irregular cycle
○ climacteric period
○ diagnostic of the breast
○ pain treatment
○ sexual discomfort
○ bladder weakness / incontinence
○ others:

_____

2. Do you suffer from the following illnesses or complaints?

○ high blood pressure
○ stroke
○ diabetes
○ migraine → ○ with aura ○ without aura
○ asthma
○ intestinal diseases
○ thyroid diseases
○ heavy or painful bleeding
○ skin changes
○ hot flashes
○ others (including cancer):

_____

3. Which medication are you taking on a regular basis?

_____

4. Do you take hormonal supplements?

○ no ○ yes → which ones?

_____

5. Did you have any surgery?

○ no ○ yes → which / when?

_____

6. Protection provided by vaccination

polio / diphtheria / tetanus _____ ○ yes ○ no
rubella _____ ○ yes ○ no
pertussis _____ ○ yes ○ no
HPV (cervical cancer) _____
_____ ○ yes ○ no ○ partly

7. Does anyone of your family members suffer from breast or genital cancer?

○ no ○ yes → who?

_____

other diseases (e.g. stroke, heart attack, genetic affections):

_____

8. Do you suffer from any allergies?

○ no ○ yes → which ones?

_____

9. How many cigarettes do you smoke a day?

○ I am a non-smoker
○ ____ cigarettes per day

10. When was your last period and do you have a regular cycle?

○ regular
_____ ○ irregular

11. Do you use any kind of contraception?

○ no ○ yes → since when / name

_____

12. Did you give birth to children?

○ no ○ yes
year: _____ ○ vaginal ○ c-section
year: _____ ○ vaginal ○ c-section
year: _____ ○ vaginal ○ c-section

13. Did you experience any problems during pregnancy or childbirth?

_____

14. Did you have one or more miscarriages?

○ no ○ yes
year: _____ which month: _____
year: _____ which month: _____

15. Have you or a close relative been diagnosed with a thrombosis or embolism?

○ no ○ yes → who? _____

16. When was your last mammography?

○ never ○ year _____

17. Have you already had a colonoscopy?

○ no ○ yes, when? _____

18. How did you know about our practice?

○ recommendation by acquaintances
○ recommentation by other doctor
○ practice sign
○ coincidence
○ internet

I agree that the gynaecological practice will contact me by phone, fax or email (usual unencrypted route, see also online appointment scheduling on our homepage) regarding appointments and medical evidence.

○ yes ○ no

date: _____

signature: _____