Medical history form

Dear patient,

Please fill out this questionnaire as completely as possible before your first visit to our practice. This will help us to get an overview of your medical history and to tailor your treatment accordingly:

First name:

Last name:

telephone number:

E-mail:

Currently working:

General practitioner (name, place):

Height:

Body weight:

Menstrual period:

Is (or was) your menstruation (period) regular?

First menstruation (period):

no menstruation (period) since:

When was your last gynecological examination?

When was the last cancer screening?

When was the last mammography/sonography?

Do you currently have any complaints? If yes, which ones?

Do you currently have problems with your sex life? If yes, which ones?

Which contraceptive methods have you used so far?

Disease (e.g. high blood pressure, diabetes, heart, liver, kidney disease, etc.):

Serious illnesses in the family:

General operations (e.g. appendectomy):

Gynecological operations:

Births: Date + Type of birth (spontaneous, caesarean section, suction cup, forceps)

Complications:

Ectopic pregnancy/sided miscarriages/abortions/ectopic pregnancies:

Do you currently wish to have children?

Are you currently pregnant or do you suspect you are pregnant?

If yes: When was the 1st day of your last period?

Medication taken on a regular basis:

Allergic reaction to the following substances (e.g. penicillin, iodine):

Consumption of:

- Nicotine
- Alcohol
- Drugs
- Other substances

Other important information:

Place, date:

signature:

Thank you for your support!

Your practice team