endokrinologikum Berlin

Allgemeine Patientendaten Gynäkologie (englisch)

Nummer: FO-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.

Your referring doctor will receive a doctor's note ❒ yes ❒ no
Name of your gynocolgist: _____
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/ hpv/ measles:
❒ yes, which _____ when? _____ ❒ no

Hight: _____ cm **Weight**:_____ kg

Max. weight (throughout your life)_____ kg, when:_____

Min. weight_____ kg, when: _____

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 on?

Surgery: what -why	Where	When

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

Medication	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 substaces and frequency of use:_____

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

Nutrition: ❒ mixed cost ❒ vegetarian ❒ vegan ❒ other:

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

Questions concerning your partner:

Is there a partner? ❒ yes ❒ no

Age?_____ State of health:_____ Children?_____ Status of spermiogram:_____

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 ❒ strong

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

Menstrual pain: ❒ yes ❒ 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?
❒ **yes**, I am currently trying to get pregnant. For appr. _____ months
❒ **yes**, but at a later point in my life In appr. _____ years
❒ **no**

Have you ever undergone fertility therapy? ❒ yes ❒ no

When: _____ Why:_____ Successfully: _____

Have you ever been pregnant? ❒ yes ❒ no

Number of pregnancies: _____ Number of births: _____

Year	Misscarriages	Aborts	Mode of birth

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