Patient Questionnaire

Thank you for taking your time to fill out this questionnaire. It is the basis for further treatment. In case of ambiguities please ask your attending gynaecologist. Your personal information ist naturally subject to the strict data protection regulations.

Name: Date of birth: Size: cm

Weight: kg; Tel.: Email:

Occupation: Date of the last gyanecological examination:

Menstruation

First day of your last menstrual period:

Are your menses regular? (approx. every 4 weeks) If not,how are they?

Do you suffer from severe menstrual pain? (painkillers necessary?):

Do you suffer from migraine? If yes, does it depend on your bleeding?

If case of migraine, do you have an aura? (e.g. a flicker in front of your eyes)?

If you have not been having regular menses since when?

Do you suffer from menopausal symptom?

Are you taking any hormonal medications in this regard?

Contraception

Which contraceptive method do you use?

Gynaecological background

where any of the following illnesses diagnosed/treated or do you have Complaints regarding Myomas or Endometriosis:

Inflammations of the fallopian tubes

Hormone dysfunction (thyroid gland, cycle dysfunction...):

Abnormal smears on the cervix (Pap smears, dysplasia):

Sickness of the breast:

Pelvic floor complaints, incontinence:

Have you been victim of sexual abuse?

Pregnancy/Births

How many pregnancies have you had so far?

Births? Complications?

Complications during pregnancy (Threatening or premature births, diabetes, high blood pressure)

Miscarriages: Pregnancyabortions:

Previous operations

Laparoscopies: Curettage:

Abdominal incisions: Operations on the breast:

Operations on the cervix: Further operations (also not gynaecological):

General background

Allergies (esp. medication, latex):

Chronic diseases (e.g. high blood pressure, intestinal and liver diseases, diabetes):

Have you had thrombosis or pulmonaryembolism?

Have you had a heart attack or stroke?

Is a blood coagulation disorder known in your case?

Do you regularly take medication? (If yes, which ones?)

Other regular therapies?

Have you been diagnosed with cancer?

Other previous serious illnesses?

Are high blood lipid levels known to you?

Do you have regular vaccinations? When last?

Do you smoke? How much/day? Do you consume excessive alcohol or drugs?

Family medical history

Are there in your close family cases of (please mention who is concerned): Hypertension?

Breast cancer, ovarian cancer, colon cancer?

Heart attack or stroke?

Thrombosis or pulmonary embolism?

Blood clotting disorder?

High blood lipids?

Any other illnesses not mentioned here?

Precautionary examination

Have you already had a mammography? If yes, when?

Have you had a breast ultrasound? If yes, when?

If you are 50 years and older, do you participate in mammography screening?

Have you had a coloscopy?

Please inform us of any new reports on you or your close relatives during your next visits. Please also let us know if you are using the "pill" for contraception, if in the near future major surgical procedures will be necessary, interventions or immobilizations (e.g. gypsum) are planned.

Date: **Signature**