Patient history form

Welcome.
We are pleased to welcome you as a new patient in our practice.
In order to be able to get a picture of your illnesses/ anamnesis and to be able to care for you in the best possible way, we need some further information from you. Of course, your information is subject to medical confidentiality.

surname:..... first name:..... date of birth: .....

current address: .....

home address: .....

telephone private:..... telephone mobile:.....

e-mail-address: .....

family doctor (in Germany): .....

material status:..... Occupation:.....

How tall are you? .....cm How much do you weigh?..... kg

1. Period with ..... Years menopause (climacteria) with.....years

Have you had the usual childhood diseases? O Yes O No , which one ?
(measles, mumps, rubella, varicella, polio or other ones)
.....

Have you received any vaccinations against HPV viruses (cervical cancer)?
O Yes O No
Number of vaccinations: ..... (month/year) .....

Do you have a valid vaccination card with the necessary vaccinations? O Yes O No

When was the last gynaecological examination? .....

When was your last mammogram (chest x-ray or screening exam)? .....

Have you had a colonoscopy? O No O Yes, when? .....

Do you have a history of cancer? 0 Yes 0 No

Which ones and in which year? .....

What form of surgery was subsequently performed and when? .....(month/year)

Chemotherapy: 0 Yes 0 No When? .....(period)

Irradiation: 0 Yes 0 No When? .....(period)

Are you aware of any allergies? 0 Yes 0 No
Please state the name of substance of the medication if intolerant .....
.....

Do you smoke? 0 Yes 0 No How many per day? .....

Do you use contraceptives (birth control pills, etc.) daily? 0 Yes 0 No
Which? ..... (name)

Do you regularly take hormones (contraception or menopause)? 0 Yes 0 No
Which? ..... (name)

Are your periods regular? 0 Yes 0 No
(Please specify pause and bleeding period, how many days of bleeding, how many days without bleeding.)

When was the last menstrual bleeding (1. and last day)? From .....to .....

Do you have chronic illnesses (e.g. diabetes, rheumatism, thyreoid disease, heart diseases)?
O No O Yes Which one? .....

Are there people in the family with cronic diseases (diabetes, rheumatism, etc.)?
Who is sick and why? .....

Are you aware of any organic damage or malformations (e.g. kidney damage, renal dysfunction, liver damage or liver dysfunction, etc.)? 0 Yes 0 No
Which one? .....

Are you currently taking medications for long-term therapy (heart, chronic diseases, antidepessants, etc.)? 0 Yes 0 No
Name(s) of the medicine .....

Do you have or have you had vascular diseases? 0 Yes 0 No
Which? ..... When? .....
(varicose veins, (lung)embolism, myocardial infarction, thrombosis)

Do you take for these illnesses drugs in long time therapy?

.....

Which operations thereby became necessary and when have they take place?

.....

Were you irradiated within the scope of the cancer illness or have you received you chemotherapy?

.....

Please, give us the periods .....
Take concerning this at the moment drugs?
Please, mention to us the names. .....

Are allergic reactions to drugs or materials known with you in drugs or, however, other allergies?
O No O Yes
Which are these? .....

Are you smokers O No O Yes .....cigarettes per day

Do you take regularly drugs to the prevention? O No O Yes.
Please, mention to us the preparation name. .....

Do you take regularly drugs in the area "Climacteric"? O No O Yes
Please, mention to us the preparation name. .....

Is your menstrual bleeding regular? O Yes O No
Please, give to us your cycle length and the length of the bleeding .....

When the bleeding has completely stopped? (mind. 1 year without bleeding) .....
(Concerns as a rule patients in the area of the climacteric)

Please, call us the period of the last menstrual bleeding before the appointment with us.
.....

Do you have illnesses in the area of the blood vessels or the heart? O Yes O No
(heavy) varicose veins, cardiac infarction, pulmonary embolism, thrombosis, high blood pressure or, however, bad circulation on account of a too low blood pressure

When have you had these illnesses? .....

Do they take concerning this regularly drugs? O Yes O No
Please, mention to us the names .....

Have you had operations in the area of the blood vessels or the heart? O Yes O No

Which operation was carried out? .....
When was it carried out? .....

Has somebody fallen ill in the female line of the familiy with breast cancer? O No O Yes
.....
Are there other people with cancer illnesses in family? O Yes O No
Which person which cancer illness?
.....

Is there a person in the family which has fallen ill with osteoporosis?
.....

Do you let operations in the area of the abdominal cavity or, however carry out of the breast?
(Scrapes, uterine operations, cyst operations, appendektomy or, however, other operations?
O Yes O No
When has this operation been carried out (month/ year)? .....

.....

Have you born children? O No O Yes
(Please, brag the respective year, the gender of the child an the kind of the exemption)
(Spontaneus birth, vacuum birth, caesarean or other)

20..... 20..... 20..... 19..... 19..... 19.....

Did you have miscarriages? O No O Yes 20..... 20..... 19..... 19.....

Do you allow to carry out a termination of pregnancy? O No O Yes
(Please, brag in each case the year and the month)