gynäkologie

STUTTGART

REGISTRATION AND MEDICAL HISTORY FORM

Dear Patient,
Welcome to our practice.
To ensure that your treatment is tailored to your needs and medical condition,
we kindly ask you to answer the following questions.
Your information will be treated with strict confidentiality and is subject to medical secrecy.

Personal information

Family name			First name	
Birth name			Date of birth	
Adress (Street, No.)				
Postal code			City	
Phone (mobile)			Phone (home)	
E-Mail			Phone (business)	
Health Insurance	☐ statutory		☐ private	☐ self-payer
Name of the insurance company				
Profession			Employer	
Height	cm		Weight	Kg
Smoking _____ Zig/Day	Alcohol	☐ never	☐ rarely	☐ regularly
Age of first menstruation			Last PAP smear	
Last mammogramm			Last colonoscopy	
previous gynecologist				
Reason for your current doctor visit				

Medical information

Last menstuation	Duration of cycle	Days of bleeding	
Do you have pain during your period?	☐ No	☐ Yes	
Allergies (pollen, penicillin...)			
Current medication			
Infektions (HIV, Hepatitis, Chlamydia, HPV...)			
HPV vaccination	☐ No	☐ Yes	When?

Please turn

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Births

Year of birth	Name	Sex	Weight	Vaginal / C-Section?

Miscarriages | abortions

Year	Week of pregnancy	noteworthiness

Contraception

- ☐ No
- ☐ Birth control pill
- ☐ Copper coil / chain
- ☐ Hormone IUD
- ☐ Vaginal ring
- ☐ Hormone patch
- ☐ Condom
- ☐ Other

Personal diseases (e.g. heart, high blood pressure, lung, gastrointestinal, diabetes, thyroid, kidney, cancer, nervous system, migraine, epilepsy, thrombosis, embolism, coagulation disorder, genetics)

-
-
-

Have you had any surgeries?

-
-
-
-

Are there any known diseases in your family? (e.g., thrombosis, embolism, heart attack, stroke, breast cancer, abdominal cancer, colon cancer, genetic diseases, malformations)

-
-

How did you hear about our practice? | Referred by:

- ☐ Doctor
- ☐ Family
- ☐ Friend
- ☐ Google
- ☐ Homepage
- ☐ Doctolib
- ☐ Practice sign
- ☐ Other

Would you like to receive information by phone, email or fax? ☐ Yes ☐ No

Would you like to be informed about preventative care appointments? ☐ Yes ☐ No

Place, date

Signature

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