

Gynecologists

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name, first name: _____ age: _____ phone-nr: _____

profession: _____ e-mail: _____

first day of your last menses: _____ how many days are between two menses: _____

is the bleeding: strong ? normal ? weak ? painful ? irregular ? bleeding in between ?

the menses lasts _____ days menopause since: _____

how old were you, when you had your first menses (appr.) ? _____ years

pregnancies: year normal delivery: yes no cesarian section forceps vacuum

1.) _____ ? ? ? ? ?

2.) _____ ? ? ? ? ?

3.) _____ ? ? ? ? ?

problems during the pregnancies (z.B. premature contractions, infections, small-for-date baby.
etc.) _____

miscarriage: ? abortion: ? extrauterin pregnancy: ?

gynecologic illnesses:

other illnesses:

operations:

allergies: _____

do you ever have a thrombosis (blood clot) _____

do you take any medicine, if yes which? _____

do you smoke, if yes, how many cigarettes a day? _____

do you drink alcohol regulary? _____

contraceptive: pill: ? which: _____ coil: ? condoms/diaphragma: ? temperture: ? nothing: ?

is there a case of breast cancer in your family, if yes, who? _____

have you ever had a mammography, if yes, when was the last (appr.) ? _____

other problems / reason of you visit: _____

Do you agree, that we will remind you of the next examination: yes ? no ?