

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:

gynekologic 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