Dear Patient,

Welcome to our clinic!

Please answer the following questions about your health conditions.

Last name, First name:	
Date of birth:	
Address:	
Home Phone:	
Cell Phone:	
E-Mail:	
Occupation:	
Primary care physician name and practice name:	

What is the reason for your visit?

When was your last gynecological exam/last preventive exam?	
When was your last mammogram?	
When was your last colonoscopy?	
Age at first period?	
First day (date) of last period?	
Frequency and length of menstrual period (e.g. every 28 days for 4 days)	

Symptoms during menstrual period?

No	Yes

Are you currently trying to conceive?	No	Yes	Since when:

Current contraceptive method	None	Pils	IUD	Tubal ligation
	Condoms	Partner had a vasecotmy		Others

Total number of births	Spontan Vaginal Deliver		Vacuum/Forceps Delivery
	Cesarean Delivery		
Ectopic Pregnancy	No	Yes/ when	
Miscarriages	No	Yes/ when	
Abortions induced	No	Yes/ when	

Have you ever received vaccinations to prevent cervical cancer (HPV vaccines)?	No	Yes	When:	
Do you take medications on regular basis?	No	Yes		
Past surgical history	No	Yes	Date/Surgery:	
Smoking status	No	Yes	How many per day:	since when:
Alcohol intake	No	Yes	Occasionally	
Drugs	No	Yes	Former/Current user	
Allergies	No	Yes		
DVT/Pulmonary Embolism	No	Yes	When:	
Cancer	No	Yes		
Are you on hormone replacement therapy?	No	Yes		

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Do you have migraines?	**No**	**Yes**	**With aura**	**Without aura**
Do you have blood clotting disorders (Factor V Leiden, Thrombophilia)?	**No**	**Yes**		

<u>Family History:</u>

Cancer	**No**	**Yes**
Blood clotting disorder	**No**	**Yes**
Heart attack/stroke	**No**	**Yes**
DVT/Pulmonary embolism	**No**	**Yes**

Other diseases	**No**	**Yes**

Is there family history of disability/birth defect/genetic disorder	**No**	**Yes**	

Acknowledgement to date collection, processing, and storage.

I hereby consent to the collection, processing, and storage of my personal data for the purpose of consultation, examination, treatment, billing, appointment, and transmission of health information by the practice. I understand that the practice may request for my medical record from other physician and service providers for the purpose of co-management. I have been informed that this consent is revocable any time in writing or by E-Mail to the practice. I waive the reporting obligation according to (Art.7 Abs.3 DSGVO). This is revocable at any time in the future

Date/Signature ____

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