Zeit für gute Vorsorge ...

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In an emergency, outside of practice opening times: Ärztefon: 0800 33 66 55

Dear Madam

When visiting our medical practice for the first time, we ask you to fill out this questionnaire as **complete as possible**.
You will help us to have a quick and good overview about your medical history. This also enables us to harmonise and optimise the future medical treatment.

Should you face problems to answer certain questions, leave the field blank and go to the next question.

family name: _____ **first name:** _____ **date of birth:** _____

job/occupation you work in at present: _____

marital status/ Job/occupation of your partner: _____ / _____

family doctor: _____

menstrual period:
first period with _____ years of age
cycle lengths (e.g. 28 days) _____ duration/strength _____ /days _____
first day or year oft the last menstruation _____

hormontherapy/contraception method which you have been using so far

hormon, anti baby pill, contraceptive coil, condoms, etc.	name of hormon, anti baby pill or coil	date/year from	until

vaccinations:

cervical cancer (HPV):	yes ☐	no ☐	don't know ☐	document at home ☐	no document ☐
twice rubella/German measles:	yes ☐	no ☐	don't know ☐	document at home ☐	no document ☐
twice chickenpox:	yes ☐	no ☐	don't know ☐	document at home ☐	no document ☐
whooping cough, year_____:	yes ☐	no ☐	don't know ☐	document at home ☐	no document ☐
hepatitis:	yes ☐	no ☐	don't know ☐	document at home ☐	no document ☐

please mark with ☑	never	only in the past	sometimes	frequently
cystitis	☐	☐	☐	
pelvic inflammatory disease	☐	☐		

your own illnesses or diseases:

diseases (e.g. migraine, high blood pressure, diabetes, heart-, liver-, kidney disease etc)

all surgeries:

date/year	type of surgical intervention

⇨ continue on the back

childbirth:

date/year	type of birth; natural (vaginal), c-section (caesarean), forceps, vacuum extraction	weight at birth	complications

total time of breastfeeding: _____ month/s _____

miscarriages / artificial abortions / tubal pregnancies:
Please mark with **x**

date/year	miscarriage	artificial abortion	tubal pregnancy

medicines/pharmaceuticals, which you use regularly:

name of pharmaceutical product	dose rate	since when (date)

allergies (what kind of reaction): **intolerances (what kind of reaction):**

consumption of:

mark with ☑	never	only in the past	sometimes	regularly
nicotine	☐	☐ till	☐	☐ /day
alcohol	☐	☐	☐	☐
drugs	☐	☐	☐	☐

nutrition mark with ☑**:**
normal nutrition: yes ☐ different kind of nutrition ☐ _____
vegetarian/vegan diet: yes ☐
ingestion of milk products: yes ☐ no ☐

serious genetic (hereditary) diseases in your family:

degrees of relationship (i.e. mother, brother etc.)	illness/disease (cancer, high blood pressure, heart attack, migraine, diabetes, thromboses/embolism/stroke, congenital heart failure (your family and also by your partner), osteoporosis, congenital hip complaint, dementia)	

additional comments and remarks: let us also know if a very high deductible could be a problem yes ☐

date: _____ signature: (digitally or later in practice):

_____

Thank you for your cooperation!

Dr. med. Bodo Grahlke