Gemeinschaftspraxis
Evelyne Bischof-Wörner
Dr. med. Caius Dragan
Frauenärzte

Dear Patient,

We would like you to enjoy the best treatment we can give you. However, this is only possible if we possess accurate information about your health, e.g. previous illnesses, operations or pregnancies. Please take the time to fill out this questionnaire while you are waiting and give it back to one of the nurses when complete.

Last name: First name:

Date of birth: Age: I weigh kg and am cm tall

Address:

Street, House no.: PLZ: Town:

Phone no.:

Email-address: Family doctor (GP):

When was your last gynaecological examination?

When did your last menstrual period begin? (dd/mm/yy):

Do you menstruate regularly? □ yes □ no

Do you have problems with your menstruation? □ yes □ no

If yes, then: □ too frequent □ too strong □ painful □ weak □ no bleeding, or □ other:

Have you ever been pregnant? □ yes □ no
Number of births:
Mode of delivery:
□ spontaneous (“normal”) □ vacuum extraction (“ventouse”) □ caesarean section
Are your children healthy? □ yes □ no
Have you ever had a miscarriage? □ yes □ no How often?
Have you ever had an abortion? □ yes □ no How often?

Have you ever had a gynaecological ailment? □ yes □ no

Have you ever had a gynaecological operation? □ yes □ no

If yes what kind of operation and when (year)?

Have you ever had a mammogram? □ yes □ no

Do you smoke? □ yes □ no How many?

Do you drink alcohol regularly? □ yes □ no How much?

Do you have or have you ever had any of the following symptoms or diseases?

Allergy to medication?	□ yes	□ no	To what?
Epilepsy?	□ yes	□ no	
Migraines?	□ yes	□ no	
Lung disease?	□ yes	□ no	
Bleeding /clotting disorder?	□ yes	□ no	
Have you ever had thrombophlebitis or a pulmonary embolism?	□ yes	□ no	
Do you have varicose veins?	□ yes	□ no	
Diabetes mellitus?	□ yes	□no	
Thyroid disease?	□ yes	□no	
Other metabolic disorder? Please specify:	□ yes	□ no	
Heart disease? Vascular disease?	□ yes	□ no	
If so, what? Cardiac failure?	□ yes	□ no	

Angina pectoris?	□ yes	□ no
Myocardial infarct?	□ yes	□ no
Irregular heart beat (“arrhythmia”)?	□ yes	□ no
High blood pressure?	□ yes	□ no
Low blood pressure?	□ yes	□ no
Valvular heart disease?	□ yes	□ no
Cerebral stroke (“TIA”)?	□ yes	□ no

Do you suffer from any infectious disease?	□ yes	□ no	
Hepatitis?	□ yes	□ no	
Immunodeficiency (HIV)?	□ yes	□ no	
Other?	□ yes	□ no	Please specify:
Liver disease (e.g. gall stones, cirrhosis)?	□ yes	□ no	
Stomach disease (e.g. ulcers, gastritis, heartburn)?	□ yes	□ no	
Diseases of the small or large bowel (e.g. Crohn’s disease, colitis ulcerosa, irritable bowel syndrome)?	□ yes	□ no	

Last name: First name: Date of birth

Kidney disease? □ yes □ no

Osteoporosis? □ yes □ no

Have you ever had cancer? □ yes □ no What kind?

Have you ever had an operation? □ yes □ no

If yes, what kind of operation and which year?

Do you use contraceptives? □ yes □ no

If yes, which method?

□ “the pill” □ intrauterine device (“IUD”, “coil”) □ condoms □ coitus interruptus □ tubal ligation □ implant

Are you taking hormone replacement therapy? □ yes □ no Please specify:

Are you taking any other regular medication □ yes □ no Please specify:

Have any of your blood relatives ever had cancer, thrombosis, embolism, heart attack or a cerebral stroke? □ yes □ no Please specify:

I confirm that I have given the above information correctly to the best of my knowledge.

In case of changes in health, I will keep you informed.

Date: Signature of patient:

I agree to the continuation of my medical records by Dr. Caius Dragan and Evelyn Bischoff-Wörner as my new gynaecologists.

Date: Signature of patient:

Thank you for taking the time to answer these questions.

Dr. C. Dragan and E. Bischof-Wörner

Last name: First name: Date of birth: