



Dear Madam

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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) _____ days duration/strength _____ days/
first day or year of the last menstruation _____

hormonotherapy and contraception method which you have been using so far;

Hormone, anti baby pill, contraceptive coil, condoms, etc.	name of hormone, anti baby pill or coil	date 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 ☐

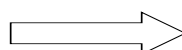
please mark with x	never	only in the past	sometimes	frequency/year
cystitis	☐	☐	☐	☐
pelvic inflammatory disease	☐	☐	☐	☐

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 to the next page

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 X	never	only in the past, till	sometimes	regularly
nicotine	☐	☐ til	☐	☐ /day
alcohol	☐	☐ til	☐	☐
drugs	☐	☐	☐	☐

nutrition(Mark with X):

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(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 ☐

Size: cm **Weight:** Kg

date _____

signature: _____

Thank you for your cooperation!

Dr. med. Bodo Grahlke