Anamnesebogen (englisch)
anamnesis - medical history

Surname:	Maiden Name:
First Name:	Date of birth:
Address:	
Telephone:	E-Mail:
Occupation:	Nationality:

Patient label

Practice stamp

Gynaecologist:

Size: cm		Weight: kg
First menstrual bleeding:	Last menstrual bleeding:	Interval & durance of menstrual bleeding:
Pregnancies: (inculding miscarriages & abortions)	Births:	Abnormalities during delivery:
Menopause:		Last mammography:
Last gynaecologic examination:		Last PAP smear result:

Vaccination against HPV: ☐yes ☐no, in case of „yes“: (Cervarix / Gardasil) When, how often:

Previous gynaecological disorders or operations:

Non-gynaecological illnesses or operations: (e. g. diabetes, high blood pressure, thyroid diseases, cardiovascular disease, liver disease, circulatory disorder, kidney disease, varicosis, cancer...)

What kind of operations have been performed?

Family history/ diseases: (e. g. cancer)

Allergies: (medicine, antibiotics, local anaesthetics, iodine, latex, soya)

Cigarettes: count/ day	Alcohol:
Infectious diseases (Hepatitis, HIV, tubercolosis):	
Contraception ☐ yes ☐ no (e. g. oral contraceptives or IUD, condom):	Are you seeking parenthood: ☐ yes ☐ no
Are you pregnant : ☐ yes ☐ no ☐ possibly	Hormone replacement therapy: ☐ yes ☐ no

Do you take medication regularly?

Do you have any medication intolerance?

place, date **patient's signature**

This document is stored in digital form in the patient's card.