

## Interne Formulare

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### FB Ki04 Medical History HER

#### Patient

Surname \_\_\_\_\_

First name(s) \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Birthname \_\_\_\_\_

#### Address:

Street, house number:

\_\_\_\_\_  
ZIP Code, city:

\_\_\_\_\_  
Phone (landline) \_\_\_\_\_

Mobile \_\_\_\_\_

E-Mail \_\_\_\_\_

Married  no  yes

Height: \_\_\_\_\_ cm / ft-in

Bodyweight: \_\_\_\_\_ kg / lbs

Responsible Health Clinic:  Vilseck  Hohenfels  Grafenwöhr

#### Life partner

Surname \_\_\_\_\_

First name(s) \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Mobile \_\_\_\_\_

### Short medical History

Last menstrual cycle? Date: \_\_\_\_\_ Duration: \_\_\_\_\_

How many days is a cycle? For example regular every 28 days, prolonged 36 days or irregular? \_\_\_\_\_

Severe menstrual cramps?  no  yes, since: \_\_\_\_\_

Severe bleedings?  no  yes

Abnormal PAP smear?  no  yes

Have you ever been pregnant?  no  yes: \_\_\_\_\_

Have you ever given birth?  no  yes (year? cesarian? Preterm?) \_\_\_\_\_

\_\_\_\_\_  
Number of children: \_\_\_\_\_

Abortions?  no  yes: \_\_\_\_\_

Miscarriages?  no  yes: \_\_\_\_\_

Age of first menstrual bleeding: \_\_\_\_\_

Do you use any family planning method?  no  yes: \_\_\_\_\_

Have you had any surgery?

no  yes: \_\_\_\_\_

Have you had any gynecological diseases?

no  yes: \_\_\_\_\_

Do you have endometriosis?  no  yes

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Erstellt von: Wawra	Freigegeben von: Kopp	Geändert durch: Maxa	Version 5
Datum: 13.01.2010	Datum: 09.01.25	Datum: 09.01.25	

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PID (pelvic infection)  no  yes

Sexually transmitted diseases  no  yes  
If yes, indicate:  Human papilloma virus (warts or cervical);  HIV;  
 Herpes  Gonorrhoea  Chlamydia

When was your last pap smear taken? \_\_\_\_\_

**By 'yes' elaborate in a separate attached sheet as necessary.**

Have you ever been diagnosed of the following conditions or received prescription for any of the following

- High blood pressure, heart condition, vascular disease or stroke?  no  yes
- Mental disorders (depression, seizures or any nervous system disorder)?  no  yes
- Any cancer, please specify  no  yes
- Joint disorders, strained or injured back, slipped disc, or any bone or muscle disorder?  no  yes
- Bleeding disorders (haemophilia, blood clots)?  no  yes
- Metabolic or hormonal diseases (e.g. diabetes, thyroid)  no  yes
- Any visual or hearing deficits?  no  yes
- Any immune system disorder not related to Human Immunodeficiency Virus (HIV)?  no  yes

Have you ever sought or received any advice or treatment due to excess use of alcohol or drugs?  no  yes

Please list the current medication:

\_\_\_\_\_

Do you have allergies?  no  yes: \_\_\_\_\_

Do you use tobacco?  no  yes

### Family History:

*Has anyone in your immediate family (mother, father, sister, brother, grandparents) had any of the following?*

Breast Cancer  no  yes

Colon Cancer  no  yes

Ovarian Cancer  no  yes

Diabetes  no  yes

High blood pressure, stroke, blood clots, or heart attack  no  yes

Please explain any "Yes" responses to the family history questions above:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Patient signature