Questionaire for HerzoDoc MVZ

Name: _____ **Surname:** _____

Address: _____ **Nationality:** _____

_____ **Phone:** _____

Date of Birth: _____ Family status: _____

Health insurance: _____

Profession: _____ Smoking (how many cigarettes): ____

Cycle: regular: 24-24-26-27-28-29-30-31-32-33 irregular: Yes

How tall are you? : _____ cm Weight: _____ Kg

Last menstruational bleeding: _____ Family doctor: _____

Pregnancy´s (year, kind of delivery): _____

Contraception: _____ Last PAP Smear (Cancer Test): _____

Last Mammography: _____ Last Coloskopie: _____

Recent gyn. Diseases: abnormal pap smear – breast disease – chronic pelvic pain – premenstrual Syndrome – vagina diseases – infections – ovarial diseases – bleeding disorders

Operations (which, Year): _____

Allergies: _____

Medication: _____

Vaccinations: Rubella – Chickenpox – HPV – Pertussis – Influenca - Tetanus

Diseases: coronary heart disease – diabetes mellitus – diseases of the blood – epilepsy eye disorders –gastrointestinal disorders – headaches – hypertension – lung disorders – mood disorders - musculoskeletal disorders – rheumatic disease - thrombosis – thyroid disease – urinary tract disorders – varicosis

Diseases in the family: Cancer-Diabetes-Hypertension-Thrombosis-Osteoporosis-Others

I agree to get a reminder for a yearly cancer screening:

_____ _____

Date Signature