



Praxis für Gynäkologie und Geburtshilfe

Zytologisches Labor

Dear patient, for the inquiry of your medical history, be so kind as to indicate the correct dates in this form, if known also the date or year; if not correct mark with 0

Address _____ Post-Code/Town _____

Telephone/Home _____ Mobile _____

EMAIL _____ Tel.Office _____

Occupation/job _____ Employer _____

marital status _____ Family Doctor _____

GYN.: 1. PERIOD: at _____ years; CYCLUS: _____ days; MENSTRUATION: _____ days

beg.of last PERIOD: _____; PREGNANCIES year/(son/daughter): _____

MISCARRIAGES year: _____; CONTRACEPTIVE METHOD: _____

ABDOMINAL/PELVIC TROUBLES year: _____

GYN.SURGERY year: _____

OTHER SURGERY year: _____

BLOODGROUP: A B O / Rh-Factor pos. / neg. (underline correct dates)

HEIGHT: _____ cm; WEIGHT: _____ kg; RUBELLA-PROTECT.: 1: _____ / pos. / neg.

INTERNAL DISEASES: intestinal tract, liver, urinary tract, cardiovascular system, lung, thyroid, apparatus of locomotion, nervous system, infectious diseases, typhoid fever, hepatitis, jaundice, AIDS, chicken pox:

DIABETES MELLITUS: _____

TUBERCULOSIS: _____

PRESCRIBED MEDICINE: _____

ALLERGIC REACTIONS: after (e.g. penicillin, iodine, plaster, hay fever):

NICOTINE: _____ cig./day; ALCOHOL: _____, gl. _____ /day; DRUGS: _____

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HERITABLE DISEASES: _____

OTHER SEVERE DISEASES (e.g.OSTEOPOROSIS)i.fam.: _____

CANCER i.fam.: _____

Last GYN.EXAMIN. (PAP-smear mo./year): __ / __ Dr. _____

Last MAMMOGRAPHY (preventive X-ray mo./year): __ / __ Dr. _____

Last ILEO-COLOSCOPY (preventive endocopy mo./year): __ / __ Dr. _____

Member of a compulsory (legal) / private insurance (underline correct date)

at in-patient treatment additional private insurance: yes / no.

Thank you for the time you spent on filling in this document,