Dr. med. Ralf Schreiber
Facharzt für Frauenheilkunde
und Geburtshilfe | Akupunktur

Family name:	**First name:**
Street:	**Zip Code/ City:**
Tel. private:	**Mobile:**
mail:	**Tel. business.:**

Dear Patient,
We would kindly request you to answer the following questions. All information given is subject to medical confidentiality. The complete answer of this form faciliates the dialogue between you and the doctor.
If you need any help please ask my medical assistants at any time.

Thank you very much!

Do you have acute problems? No O Yes O

When did you have your last PAP smear? :

When did you have your last menstruation? :

How often do you have your menstruation?:

Body height: **Weight:**

Do you smoke? **No O** **Yes O** How much?_____

Do you take a contraceptive pill/ ring? **No O** **Yes O**
Which one?_____ Since?_____

Do you have a contraceptive coil? **No O** **Yes O**
Which one?_____ Since ?_____

Do you have children?

Year?	Vaginal delivery?	Vacuum extractor? Forceps?	Cesarean?	Breast fed?

Did you ever have an abortion? **No O** **Yes O**
Year?_____

Did you ever have an miscarriage? **No O** **Yes O**
Year?_____

Did you ever have an operation? (especially breast, abdomen, tubal sterilisation)
No O **Yes O**

Year?	Which one?

Have you been vaccinated?
O hepatitis O rubella O HPV (cervical cancer)
Etc.:_____

Do you have allergies? No O Yes O
If yes, what kind of allergies:_____

Are you hypersensitive or allergic to any medication? No O Yes O

_____

_____

_____

Do you / did you suffer from following diseases? NO O
If yes, please tick as appropriate

- **O blood pressure**
- **O diabetes mellitus**
- **O migraine O with neurological symptoms O without**
- **O Increased blood colesterol/ lipids**
- **O asthma**
- **O paralysis, seizures**
- **O thyroid illnesses**
- **O breast cancer**
- **O liver diseases, jaundice, hepatitis**
- **O Intestinal diseases**
- **O blood diseases, coagulation disease**
- **O diseases of the uterus or the ovaries:**_____
- **O Infectious diseases (HIV, hepatitis)**

Do you take medication regularly? No O Yes O
Which one?:

_____

_____

_____

_____

Is there any of the following diseases in your family?

- **O cancer (especially breast, ovaries, intestines) :** _____
- **O coagulation diseases, blood clots:** _____
- **O stroke , heart attack minor 60 years in a first-grade relative**
- **O genetic disorders? Familiar predisposition?:**_____

Maritial status?
- O unmarried
- O solid partnership
- O married
- O divorced
- O widowed

Profession?_____

Date:_____ Signature:_____