FB Ki04 Medical History

Patient

Surname_____

First name(s)_____

Birthdate _____ Age _____

Birthname_____

Adress _____

Phone (landline)_____

Mobile_____

E-Mail _____

Married ☐ no ☐ yes

Height: _____ cm / ft-in

Bodyweight: _____ kg / llbs

Life partner

Surname_____

First name(s)_____

Birthdate _____ Age _____

Adress _____

Phone (landline _____

Mobile _____

E-Mail _____

Married ☐ no ☐ yes

Height: _____ cm / ft-in

Bodyweight :_____ kg / llbs

Responsible Health Clinic: ☐ Vilseck ☐ Hohenfels ☐ Grafenwöhr

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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

PID (pelvic infection) ☐ no ☐ yes

Sexually transmitted diseases ☐ no ☐ yes
If yes, indicate: ☐ Human papilloma virus (warts or cervical); ☐ HIV;
☐ Herpes ☐ Gonorrhea ☐ 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 questens above:

_____

_____

_____
Patient signature