GYNAECOLOGY MEDICAL HISTORY FORM

(to be completed by the patient)

PATIENT DATA

surname, first name

address

occupation | telephone number

date of birth | mobile phone

general practitioner | e-mail address

GENERAL INFORMATION

What is the reason for your current visit?

body size _____ cm | body weight _____ kg

Do you take medication regularly? ☐ No ☐ Yes, the following:

Are you a smoker? ☐ No ☐ Yes, _____ cigarettes/day

Do you suffer from allergies/intolerances? ☐ No ☐ Yes, the following:

Do you have a vaccination against cervical cancer? ☐ No ☐ Yes, date:

Information on mentrual cycle

first menstruation at ____ years | No menstruation for ____ years

Is/was your menstruation regular? ☐ No ☐ Yes, every _____ days

GYNAECOLOGICAL INFORMATION

date of your last gynaecological examination/cancer screening:

Were there any abnormalities during your last gynaecological examination ? ☐ No ☐ Yes, the following:

Are there any gynaecological diseases of the breast? ☐ No ☐ Yes, the following:

births number: | by caesarean section: | with forceps/suction bell:

miscarriages number: | abortions: | ecptopic pregnancy:

Were there any complications during birth? ☐ No ☐ Yes, the following:

How do you currently use contraception?

GENERAL DISEASES

own diseases: ☐ No ☐ Yes,

if so, please also name non-gyn. diseases (e.g. abdomen, sexually transmitted diseases, blood pressure, diabetes, thyroid, heart, stroke, cancer, coagulation disorders/ thrombosis/embolism, epilepsy, depression, autoimmune or hereditary diseases, infections e.g. hepatitis, HIV, etc.)

Have you had any operations in the past? ☐ No ☐ Yes,

if so, when/what/if applicable, which hospital? (e.g. appendix, hernia, gall bladder, breast, stomach/intestine, genital area, cosmetic surgery)

Are/were there any illnesses in the family? ☐ No ☐ Yes,

if so, are there or have there been serious illnesses (e.g. cancer, coagulation disorder - see above) in the immediate family (e.g. parents, siblings, children)?
If yes, which diseases and at what age did they occur?

I hereby confirm that the information I have provided is correct; date & signature patient/ legal representative

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PATIENT DATA

surname, first name

date of birth

e-Mail address

telephone number

Mobil phone

I hereby agree that MVZ Lipsity may pass on both sample material and all necessary data (e.g. name, age, address, insurance status, any necessary information on previous illnesses and previous findings) to alphaomega Labor GbR for the provision of laboratory services.
I am aware that my blood and other body materials as well as the necessary personal data may also be passed on to other laboratories for the performance of rare special analyses.
The data will only be passed on to accredited/certified contract laboratories that are subject to the legal requirements for confidentiality and data protection.
Furthermore, I agree that, if necessary, my data may also be made accessible to other specialist practices belonging to MVZ Lipsity, e.g. in the event of joint further treatment.

☐ Yes, I agree that my findings and the necessary data may be sent to cooperating medical facilities to optimise treatment by fax, e-mail or the KIM (Kommunikation im Medizinwesen) communication service.

☐ Yes, I agree that my e-mail address and telephone number may be used for the allocation of appointments and appointment reminders via the online appointment tool Doctolib can be used.

☐ I have been informed that I can revoke this consent in writing at any time (Art. 7 para. 3 GDPR).

date & signature patient/ legal representative