Dr. med. F. Nassir
Frauenarztpraxis

Medical history form

Dear patient

Since we have not yet met, we would like to ask you to complete this form as fully as possible. This will help us to obtain a quick overview and detailed information on any previous illnesses or medical risks and to provide the best possible care at our practice. This is why it is very important that you bring the completed form to your first consultation.

Please bear in mind that if you do not bring the completed form to your first consultation, we will have to arrange a new appointment which allows enough time for us to fill it out with you. We need the completed form in order to be able to hold a detailed first consultation.

Please ask us if you need help completing the form.

Family name: ____________________ First name: ____________________

Address: ____

Date of birth: ____________________ Height: __________ Weight: __________

Telephone: ____________________ Mobile: ____________________

Email: ____

General practitioner: ____

When was your last cancer screening (Pap-smear) with a gynaecologist?

____

Have you ever had a coloscopy? ☐ Yes ☐ No

If yes, when? ____

Have you ever had a mammography? ☐ Yes ☐ No

If yes, when? ____

Do you know if you have any allergies? ☐ Yes ☐ No

If yes, what are you allergic to? ____

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What kind of contraceptive methods have you used?

Method	from	to

General illnesses:

Illness	Since (first diagnosed)

Regular consumption of:

Substance	How much per day/week/month?
Cigarettes	
Alcohol	
Drugs (which ones)	

Illnesses in your family (please put a cross):
(if known, give age of person at time of illness)

Illness	Father	Mother	Siblings Details Brother/sister	Grandparents	Aunts	Uncles
Breast cancer (mother's or father's side of the family						
Cancer of the uterus or cervix						
Colon cancer						
Heart attack						
Stroke						
Thrombosis						
Any form of cancer						

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General surgical operations:

Date	Type of operation

Gynaecological surgical operations:

Date	Type of operation	Hospital/practice

Births/delivery:

Date	Girl/boy	Type of birth	Complications	Hospital

Other pregnancies:

Date	Miscarriage, ectopic pregnancy (right/left?)	Abortion

Medicaments:

Medicament/illness	Dose	Since

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Other:

____

____

Would you like a reminder before your next appointment? ☐ Yes ☐ No

Please bring your vaccination records with you!

Please send any test results you would like to show us by email or fax in advance.

Signature: ______________________________ Date: ______________________________