


Registration gynecology

Patient's data



Are there any previous medical reports?

If so, please have a copy with you at your appointment (hospital reports, laboratory results...)

Date

Patient
Surname, name
Street, house no.
Zip code, city
Date of birth
landline no.
mobile no.
email address
profession
insurance company

further information (about the patient)
height: <input style="width: 50px;" type="text"/> cm
weight: <input style="width: 50px;" type="text"/> kg
HPV vaccine: <input type="checkbox"/> yes <input type="checkbox"/> no
Billing address (in case of private insurance)
Surname, name
Address: (only if different)

Questionnaire gynecology

Are you pregnant?	
<input type="checkbox"/> no	<input type="checkbox"/> yes
First day of last period:	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="J"/> <input type="text" value="J"/>
Number of pregnancies:	<input type="text"/>
Number of births:	<input type="text"/> <input type="checkbox"/> spontaneous <input type="checkbox"/> caesarean section
Number of children:	<input type="text"/>
Number of abortions:	<input type="text"/>
Date of last cancer screening:	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="J"/> <input type="text" value="J"/>
Do you regularly get your period?	
<input type="checkbox"/> yes	<input type="checkbox"/> no
Are there any hereditary diseases or congenital disabilities in your family?	
<input type="checkbox"/> yes	<input type="checkbox"/> no
Are there any cases of cancer in your family?	
<input type="checkbox"/> yes	<input type="checkbox"/> no
Are there cases of breast cancer or ovarian cancer in your family?	
<input type="checkbox"/> yes	<input type="checkbox"/> no
Do you smoke?	
<input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> No, but I used to smoke.
Do you regularly drink alcohol?	
<input type="checkbox"/> yes	<input type="checkbox"/> no
Do you have elevated blood lipid levels (cholesterol, triglycerides...)?	
<input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> not known
Has anyone in your close family (parents, siblings...) had a heart attack or stroke before the age of 65?	
<input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> not known
Has someone in your close family (parents, siblings...) been diagnosed with a lipid metabolism disorder?	
<input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> not known
Do you suffer from an excessive amount of sweating?	
<input type="checkbox"/> yes	<input type="checkbox"/> no

Questionnaire gynecology

Have you suffered from any of the following diseases:

Please check any that apply.

- | | | |
|--|--|--|
| <input type="checkbox"/> Thrombosis/ pulmonary embolism | <input type="checkbox"/> Circulatory and vascular diseases | <input type="checkbox"/> Sugar diseases |
| <input type="checkbox"/> Chronic illness of bladder or kidneys | <input type="checkbox"/> Tumor diseases | <input type="checkbox"/> Liver diseases |
| <input type="checkbox"/> Nerve issues | <input type="checkbox"/> Thyroid diseases | <input type="checkbox"/> Lung and respiratory diseases |
| <input type="checkbox"/> Skeletal system diseases | <input type="checkbox"/> Mental diseases | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Lipid metabolism disorders | <input type="checkbox"/> Rheumatic diseases |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Other (here not mentioned) | |

Are you under medical treatment?

- yes no

Do you have any allergies or drug intolerances?

- yes no

Do you experience a tiredness that is not adequately relieved by sleep and rest?

Please think about whether you're often tired or exhausted, even though you had enough or more sleep/rest than usual.

- yes no

Do you lose urine while laughing, sneezing or coughing?

- yes no

Do you experience issues with defecation?

- yes no

Is your blood pressure

- too high normal too low unknown

Do you regularly take medication?

Please note which medication you take on a regular basis.

- no yes, name of the drug:

Has your uterus been removed?

- yes no

Have you had an uterine curettage?

- yes no

Do you regularly take hormone preparations?

- yes no

Questionnaire gynecology

Which contraceptives do you use?		
<input type="checkbox"/> pill	<input type="checkbox"/> copper IUD	<input type="checkbox"/> hormonal IUD
<input type="checkbox"/> condom	<input type="checkbox"/> not necessary	<input type="checkbox"/> other method
Have you had a mammography?		
<input type="checkbox"/> yes	<input type="checkbox"/> no	
Do you already had a medical examination to determine your blood clotting disorder?		
<input type="checkbox"/> yes	<input type="checkbox"/> no	
Do you bruise regularly? (hematoma)		
Please think about whether you often bruise, even without a known cause?		
<input type="checkbox"/> yes	<input type="checkbox"/> no	
Do you often experience nosebleeds or gumbleeds?		
Please think about whether you often experience nose and gum bleeds without a known cause.		
<input type="checkbox"/> yes	<input type="checkbox"/> no	
Do you experience any prolonged bleeding after small cuts / wounds?		
Please think about whether you experience prolonged bleeding after small wounds / cuts, do they take unusually long to heal?		
<input type="checkbox"/> yes	<input type="checkbox"/> no	
Do you experience prolonged or strong bleedings after surgeries?		
Please think about whether you have lost an usual amount of blood during prior surgeries, maybe even needed a blood transfusion?		
<input type="checkbox"/> yes	<input type="checkbox"/> no	
Have you experienced other unusual bleedings?		
<input type="checkbox"/> yes	<input type="checkbox"/> no	
Have you ever had a venous thrombosis?		
<input type="checkbox"/> yes	<input type="checkbox"/> no	
Have you had a pulmonary embolism?		
Please think about whether you have experienced one or multiple pulmonary embolisms. A pulmonary embolism is a blockage of one or multiple pulmonary arteries..		
<input type="checkbox"/> yes	<input type="checkbox"/> no	

This questionnaire is for your anamnesis. Your data is only processed within the CBT.

If you want to file a complaint, you can find information about patient rights on our website: www.cbtmed.de under „Datenschutz“

Furthermore you have the right to revoke your approval under the following email address: widerruf@cbtmed.de, with future effect.

place, date



Signature of patient / legal representative