Dr. med.
Suzana Spethmann
Fachärztin für Frauenheilkunde
und Geburtshilfe

Dear patient,

welcome to our practice. The following details are very important for us in order to provide you with the best treatment. Please sign at the end of document with your signature.

personal details:

surname	first name	date of birth
street	number	zip, place
phone	mobile	
email-address		
profession	family doctor	

medical history:

height: _____ weight: _____

first menstrual bleeding with _____ years date of last menstrual bleeding: _____

Menstrual cycle length:

- ☐ less than 26 days
- ☐ every 26 to 28 days
- ☐ for over 30 days

- ☐ periodically
- ☐ irregular

Are you vaccinated against HPV? ☐ Yes, completely ☐ Yes, partially ☐ No

Are you pregnant: _____ do you smoke? _____/ How much daily?

Do you drink alcohol? Not at all ☐ rarely ☐ occasional ☐ daily ☐

Please turn over the page!

Do you have allergies against medications, food?

_____

Which medications are you taking?

_____

Do/did you take birth control, contraceptive pills or any other hormonal pills? If yes, which?

_____

Previous pregnancies/births:

month/year	week of pregnancy birth	c-section, force cup, abortion, abruption

Do you have or had any of the following conditions? Please circle all that apply

- o high blood pressure
- o varicose vein
- o thrombosis
- o cardiac arrest
- o stroke
- o gastric disease
- o thyroid disease
- o diabetes mellitus
- o blood clotting disease
- o bleeding disorder
- o liver disease
- o kidney disease
- o aconuresis
- o mental disorder
- o epilepsy
- o asthma/COPD
- o cancer
- o osteoporosis
- o migraine
- o other

If one or more conditions:

Which condition since when/date of onset

year	disease

Please fill out next page!

Did you have any surgeries?

year	surgery

Illness in your family (parents, siblings, kinship)?

- high blood pressure
- diabetes mellitus
- breast cancer
- cardiac arrest/stroke
- thrombosis
- ovarian cancer
- other cancer diseases
- genetic defects/malformations

When was your last gynaecological examination? _____

When was your last colonoscopy? _____

When was your last mammography? _____

Agreement for data collection, -processing and -retention

Here with I agree to the collection, processing and retention of my personal data for the purpose of guidance, examination, treatment, payment settlement, and communication of appointments and health-related information by the practice.

I have been informed that I can withdraw my consent at any point either in writing or by eMail to the practice.

I am aware that withdrawing my consent does not impact on the legality of the handling of information until withdrawal.

_____ _____

date signature

Thank you so much!