

**Dear Patient,
a warm welcome to our practice**

First off all, we need some information about you and your medical records

Last Name , First Name: _____

Date of birth: _____

Phone home : _____ Other: _____

Your profession: _____ Email adress: _____

Health insurance: _____

What is the reason for your visit ?

When were you have seen a gynecologist? _____

Have you ever had a coloscopy ? no yes

When and where ?

Have you ever had a mammography ? no yes

When and where ?

Have you had any surgery?
Do you have any conditions or allergies ?

Have you had a pregnancy before ? If so, how did you deliver ?
Have you ever had a miscarriage?

Do you take regular medication? If so, which ?

Do you smoke ? yes no How many cigarettes per day? _____

Diseases in the family:

	father	mother	others	grandparents
Stroke/ thrombosis				
Heart attack				
Breast cancer				
Colon cancer				
Cancer in general				

Other information that we might need:

Signature : _____

Date : _____

Thank you for your help