GynPraxis

Dr. Ernst & Kolleginnen

Last name: First name: Date of birth:

Address: Mail:

Phone number: Profession:

Height: Weight: First day of last period:

Age at first period: Intervals of bleedings: How long is the bleeding:

Your contraceptive method:

Have you given birth to children? when?

Did you have problems during pregnancy or delivery? which?

Have you had miscarriages? when?

Have you had any operations? which kind?

Do you have any diseases? which?

Do you take any medicine?

Do you have any allergies?

Do you suffer from migraine? Aura? Do you smoke?

Does anyone in your family suffer from cancer? who? which kind?

Have you or a family member ever had a thrombosis/pulmonary embolism/stroke/heart attack?

who? what kind?

The name of your family doctor: