Praxisgemeinschaft
AM ENGLISCHEN GARTEN

Fachärztinnen für Frauenheilkunde
80539 München • Kaulbachstr. 41
Tel: 089 – 28777905
Fax: 089 – 28675505
www.praxis-am-englischen-garten.de

QUESTIONNAIRE OF ANAMNESIS

Dear patient,

if you visit our practice for the first time, we would ask you to fill in this questionnaire completely, if possible.
Thereby, you can help us to get a quick overview of your anamnesis and to adjust your treatment.
Please ask if you have any problems when filling in the questionnaire.

last name: _____ first name: _____
address: _____
date of birth: _____
body height: _____ body weight:_____
occupation: _____
telephone number: home: _____ office: _____
mobile: _____
e-mail: _____
general practitioner: name: _____ location: _____

Menstruation: first menstruation (period) with _____ years
no menstruation (period) for _____ years
Is or was the menstruation at regular intervals? Yes, every ____ days
No, _____

Did you have a vaccination against any of the following diseases, and if yes, when?

hepatitis A ☐ _____ hepatitis B ☐ _____
tetanus ☐ _____ diphtheria ☐ _____
polio ☐ _____ tuberculosis ☐ _____
HPV ☐ _____ whooping cough ☐ _____
measles, mumps, rubella (MMR) ☐ _____
other (e.g. influenza) ☐ _____

When was the first gynaecological examination? _____
When was the last pap smear? _____
When was the last mammography/sonography? _____
Do you have any afflictions at present? No ☐ _____
Yes, which ☐ _____

Contraceptive methods that have been used as yet:
Methods: pill, patch, intravaginal ring, coil, three-month injection, spaying, condom, etc.

method	from	until

Specific ailment:

ailment (e.g. high blood pressure, diabetes, cardiac-, hepatic-, renal disease)

Serious ailments in the family:

degree of kinship (e.g. mother, brother)	Ailment (cancer, high blood pressure, diabetes, bleeding disorder/coagulopathy, hereditary disease)

General surgeries (e.g. appendix):

date	kind of procedure

Gynaecological surgeries:

date	kind of procedure

Deliveries:

date	kind of birth (spontaneous, Caesarean, ventouse, obstetric forceps)	Weight at birth	complications

Miscarriages, termination of pregnancy, tubal pregnancy:

date	miscarriage (tick)	termination (tick)	tubal pregnancy (specify side)

Do you wish to have children at present?

Yes, since ☐ _____

No ☐

Are you currently pregnant or do you suppose you might be?

Yes ☐ No ☐

If yes, when was the first day of your last period? _____

Do you have an allergic reaction to any substances?

No ☐

Yes, to ☐ _____

Consumption of: (tick)	previously	occasionally	regularly
nicotine			
alcohol			
drugs			

Other matters:

_____

_____

_____

date _____ signature _____

Thank you for your cooperation!

Praxisgemeinschaft am Englischen Garten