Dear patient!

Please help us with our work. Please answer the following questions.

Last name: ____________________________________

First name: _____________________________________

What is your current telephone number?

____

e-mail: ____

What is your job title? _____________________________________

Who is your family doctor? _________________________________

General medical history:

Age: years _______

Height and weight: cm ________ kg________

Do you have children? Yes ❒ No ❒

Have there been any miscarriages? Yes ❒ No ❒

Number _____

Have you had any abortions? Yes ❒ No ❒

Number _____

Are you currently pregnant? Yes ❒ No ❒

Have you had any gynaecological operations? Yes ❒ No ❒

When was the first day of your last period? ____

How heavy is your bleeding? Light ❒ Medium ❒ Heavy ❒

Do you have irregular periods? Yes ❒ No ❒

Have you had an abnormal smear test? Yes ❒ No ❒

Do you suffer from allergies? Yes ❒ No ❒

If yes, which ones?

____

How have you used contraception so far? Which one?

____

How long have you been using this method of contraception?

____

Are you satisfied with your current method of contraception?

satisfied? Yes ❒ No ❒

Sexual history:

Are you at increased risk of sexually transmitted sexually transmitted diseases/infections? Yes ❒ No ❒

Does your partner have an increased risk ofsexually transmitted diseases/infections? Yes ❒ No ❒

Are you prone to vaginal infections (burning, itching, discharge)? Yes ❒ No ❒

Are you prone to inflammatory genital diseases? Yes ❒ No ❒

Do you have pain during sexual intercourse? Yes ❒ No ❒

Do you have or have you had any cardiovascular diseases or related risks? Yes ❒ No ❒

Do you have or have you had high blood pressure? Yes ❒ No ❒

Do you smoke? Yes ❒ No ❒

If yes, how many cigarettes a day? ____

Have you had a heart attack? Yes ❒ No ❒

Have you had a stroke? Yes ❒ No ❒

Do you suffer from migraines or regular headaches? Yes ❒ No ❒

Do you have a heart defect? Yes ❒ No ❒

Have you and/or your siblings had any cardiovascular disease? Yes ❒ No ❒

Did your parents under the age of 45 have had cardiovascular diseases? Yes ❒ No ❒

Is a coagulation disorder known? Yes ❒ No ❒

Cancer

Have you had breast cancer or ovarian cancer? Yes ❒ No ❒

Does breast cancer or ovarian cancer run in your family?

Yes ❒ No ❒

If yes, with whom? _______________________________________

Do you have a liver tumour (benign and/or malignant)? Yes ❒ No ❒

Metabolic diseases

Do you suffer from a thyroid disease? Yes ❒ No ❒

Do you suffer from a blood sugar disease (diabetes mellitus)? Yes ❒ No ❒

Do you have a family history of diabetes mellitus? Yes ❒ No ❒

Do you have a lipometabolic disease associated with elevated blood lipid levels Yes ❒ No ❒

Do you suffer or have you suffered from any disease of the liver and/or gall bladder (e.g. cirrhosis of the liver, jaundice, hepatitis)? Yes ❒ No ❒

Do you suffer from inflammatory bowel disease (e.g. Crohn's disease)? Yes ❒ No ❒

Do you suffer from kidney disease? Yes ❒ No ❒

How would you rate your general health? Good ❒ Average ❒ poor ❒

Other diseases:

____

____

Do you take any medication and if so, which:

____

____

Geseke, den__________________ Signature: ______________________________