



# Anamnesis sheet for patients

Formblatt K1 FB PF 01-3

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Last Name, First Name:			Date of birth:		
phone home:		mobile number:		email	
size:		weight:	last period:		first period:
<input type="checkbox"/> single	<input type="checkbox"/> partnership	<input type="checkbox"/> married	<input type="checkbox"/> separated/divorced		<input type="checkbox"/> widowed
family doctor:			your profession:		

<b>Births:</b>				
<input type="checkbox"/> none	<input type="checkbox"/> number of children	<input type="checkbox"/> cesarean section	<input type="checkbox"/> complications	<input type="checkbox"/> artificial insemination
miscarriages	<input type="checkbox"/> 1	<input type="checkbox"/> 2 or more	<input type="checkbox"/> ectopic pregnancy	

<b>Previous illnesses/ risks or more:</b>			
<input type="checkbox"/> none	<input type="checkbox"/> Inflammation of the ovaries /uterus	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> lung disease
<input type="checkbox"/> smoking cigarettes	<input type="checkbox"/> thrombosis/embolism	<input type="checkbox"/> heartattack	<input type="checkbox"/> kidney disease
<input type="checkbox"/> breast cancer	<input type="checkbox"/> increased blood levels	<input type="checkbox"/> stroke	<input type="checkbox"/> thyroid disease
<input type="checkbox"/> ovarian cancer	<input type="checkbox"/> diabetes	<input type="checkbox"/> varicose veins	
<input type="checkbox"/> chronic diseases:			
<input type="checkbox"/> other:			
<input type="checkbox"/> operations:			
<input type="checkbox"/> medication:			
<input type="checkbox"/> allergies:			
<b>vaccinations:</b>			
<input type="checkbox"/> measles / mumps / rubella ; <input type="checkbox"/> HPV; <input type="checkbox"/> chickenpox; <input type="checkbox"/> other:			

<b>Illnesses in the family:</b>			
<input type="checkbox"/> thrombosis/embolism	<input type="checkbox"/> breast cancer	<input type="checkbox"/> ovarian cancer	<input type="checkbox"/> colon cancer
<input type="checkbox"/> hereditary diseases	<input type="checkbox"/> disabilities	<input type="checkbox"/> diabetes	<input type="checkbox"/> other

date	signature		
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