Praxisgemeinschaft
AM ENGLISCHEN GARTEN

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Anamnesis form

Dear Patient,

A warm welcome to our practice! By fillling out this form to your best ability, you help us gain an overview of your medical history and enable us to adjust our treatment to your needs.

How can we reach you? landline: ..... mobile: .....

e-mail adress: .....

current profession: .....

your height: ..... cm your weight: ..... kg

Are you vaccinated against following diseases? If yes, when was the last vaccination?

hepatitis A / B ○ no ○ yes, when .....

tetanus /diphteria/whooping cough ○ no ○ yes, when .....

polio ○ no ○ yes, when ..... HPV: ○ no ○ yes, when.....

covid 19 ○ no ○ yes, when.....

measles, mumps, rubella ○ no ○ yes, when.....

other vaccination .....

When did you have your first period? At the age of ..... Last period: .....

Is your period consistent? ○ no ○ yes, every ..... days

Do you experience pain during your period? ○ no ○ yes, how strong? .....

When was your last gynaecological check-up/cancer screening? .....

Have you ever had a breast ultrasound/mammography? ○ no ○ yes, when .....

Have you ever had a colonoscopy? ○ no ○ yes, when .....

Do you have any discomfort/ailments at the moment? ○ no ○ yes, please elaborate

.....

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Are you using contraception at the moment? ○ no ○ yes, I'm using the following

.....

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Do you have any pre-existing medical conditions (e.g. diabetes, migrane, headaches, high bloodpressure?)

○ no ○ yes, which .....

.....

Have you had any operations in the past? ○ no ○ yes, the following

date	type of operation

Is there anyone with a serious illness in your family? (parents, grandparents, siblings)

person	disease (e.g. thrombosis,diabetes, hypertension, cancer, stroke)

Do you regularly take medication and if yes, which dose?

medication	dose	since

Do you have any allergies e.g. medication, food intolerances, house dust/pollen allergy?
○ no ○ yes, allergic to .....

What does your diet look like? .....

Do you suffer from a sleeping disorder? ○ no ○ yes, since .....

Are you active regularly? ○ no ○ yes, what type of sport .....

Do you smoke? ○ no ○ yes, ... cigarettes per day

How much alcohol do you consume per week? .....

Have you had any miscarriages/abortions/ectopic pregnancies?

date	miscarriages	abortions	ectopic pregnancies

Have you birthed any children up until now?

date	type of birth	weight at birth	complications

Do you wish for children at the moment? ○ no ○ yes, since .....

Are you currently pregnant? ○ no ○ yes, week of pregnancy.....

Anything to add:

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