New Patient Form

Gynecologists Dr. med. Bettina Schulz & Dr. med. Heike Zwahr

Gynecology & Obstetrics, Psychotherapy

Dear Patients,
If you visit our office for the first time, we ask you to fill out this questionnaire as completely as possible.
This will help us to get a quick overview of your medical history so that we can tailor treatment accordingly.

Please contact us if you have any questions when filling out the form. Thank you for your help!
Your Dr. Bettina Schulz, Dr. Heike Zwahr and the team

Last Name: . . . . . .

First name: . . . . . .

Date of birth: . . . . . Age: . . . . . .Tel.: . . . . . .

Address: . . . . . .

General Practitioner: . . . . . .

Co-treating doctors/specialists: . . . . . .

. . . . . .

Menstrual history

At what age did your period start? . . . . . .Your last period was on: . . . . . .

Is your cycle regular? ☐yes☐ no: . . . . . .

Cancer-Prevention

When was your last PAP smear/cancer screening? . . . . . .

When was your last mammography? . . . . . .

Have you ever had a breast ultrasound? ☐ no ☐ yes, when:. . . . . .

Have you ever had a colonscopy? ☐no ☐ yes, when: . . . . . .

Contraception/Birth control methods (pills, IUD, hormone ring, condom, …)

Method . . . . . since . . . . . till . . . . . .

Method . . . . . since . . . . . till . . . . . .

Method . . . . . since . . . . . till . . . . . .

Do you currently have any gynecological discomforts/pain/complaints?

☐ no ☐ yes: . . . . . .

. . . . . .

Do you have any pre-existing health conditions? (e.g. high blood pressure, diabetes, asthma, …)

☐ no ☐ yes: . . . . . .

. . . . . .

Have you ever had any general operations?

☐ no ☐ yes: . . . . . .

. . . . . .

Have you ever had any gyno operations?

☐ no ☐ yes: . . . . . .

. . . . . .

Are there any malicious diseases in the family history? (e.g. Breast cancer, …)

☐ no ☐ yes: . . . . . .

Have you had any childbirths?

☐ no ☐ yes, how many: . . . . . .

. . . . . .

when: . . . . . complications: . . . . . .

Have you had any miscarriages/abortions/ectopic pregnancies?

☐ no ☐ yes, how many: . . . . . .

. . . . . .

Do you currently have a desire to have children?

☐ no ☐ yes, since: . . . . . .

Is there a possible pregnancy/do you suspect that you are pregnant?

☐ no ☐ yes: . . . . . .

. . . . . .

If yes, when was your last period? . . . . . .

Do you take any medications regularly?

Name: . . . . . Dosage: . . . . . since: . . . . . .

Name: . . . . . Dosage: . . . . . since: . . . . . .

Name: . . . . . Dosage: . . . . . since: . . . . . .

Are you allergic to any medications?

☐ no ☐ yes, which: . . . . . .

. . . . . .

Do you cosume any of these substances?

Nicotine: ☐no ☐yes ☐occasionally Cannabis: ☐no ☐yes ☐occasionally

Alcohol: ☐no ☐yes ☐occasionally other: ☐no ☐ yes ☐ occasionally

Do you have any requests/personal concerns?

☐ no ☐ yes: . . . . . .

. . . . . .

. . . . . .

Date: . . . . . Signature: . . . . . .