g centrum
komplexní péče o ženu

New Patient Questionnaire

Academic title, Name, Surname: .....

Surname at birth: ..... **Date of birth:** .....

Health insurer (code): ..... **Personal ID number:** .....

Address, including postal code: .....

E-mail: .....

Marital status: ..... **Mobile phone:** .....

Profession: ..... **Phone (home):** .....

Employer: ..... **Phone (office):** .....

Weight: ..... **Height:** ..... **BMI:** .....
(to be inserted by a nurse)

FAMILY HISTORY: Has any of your close relatives experienced any of the following diseases? If yes, please check the appropriate disease (specify the family member).

◯ high blood pressure	◯ cancer	◯ thyroid disease
◯ heart disease	◯ kidney disease	◯ congenital defects
◯ stroke	◯ bleeding disorders	◯ diabetes
◯ epilepsy	◯ multiple pregnancy	◯ breast disease

PERSONAL MEDICAL HISTORY: Have you ever been treated for any of the following problems?

• frequent or severe headaches	◯ yes	◯ no	• heart disease	◯ yes	◯ no
• high blood pressure	◯ yes	◯ no	• epilepsy	◯ yes	◯ no
• asthma, chronic bronchitis	◯ yes	◯ no	• diabetes	◯ yes	◯ no
• high blood lipids (cholesterol)	◯ yes	◯ no	• chickenpox	◯ yes	◯ no
• thrombosis, embolism	◯ yes	◯ no	• breast disease	◯ yes	◯ no
• gallbladder disease	◯ yes	◯ no	• thyroid disease	◯ yes	◯ no
• recurrent urinary tract infections	◯ yes	◯ no	• cancer	◯ yes	◯ no
• anaemia	◯ yes	◯ no			

• liver disease (infectious jaundice, mononucleosis)	◯ yes	◯ no
Are you interested in influenza vaccination?	◯ yes	◯ no
Have you been vaccinated against type A or type B hepatitis?	◯ yes	◯ no
If you are 50 or older, have you had faecal occult blood test in the last year?	◯ yes	◯ no
Are you interested in having faecal occult blood (FOBT)?	◯ yes	◯ no
If you are 50 or older, have you had densitometry in the last year?	◯ yes	◯ no
Are you interested in having densitometry - osteoporosis	◯ yes	◯ no
Are you interested in having genetic tests for the risk of female cancer, thrombophilic states?	◯ yes	◯ no

Other serious diseases - specify .....

HAVE YOU EVER HAD SURGERY? Please specify in chronological order:

Year	Type of surgery	Hospital	Possible complications
1.			
2.			
3.			
4.			
5.			

GYNAECOLOGICAL TREATMENT

- ◯ treatment of the cervix (conization)
- ◯ hormonal treatment of irregular cycle
- ◯ procedures for irregular bleeding (curettage)
- ◯ deep gynaecological inflammation with fever
- ◯ ovarian cysts
- ◯ repeated discharge
- ◯ treatment of infertility
- ◯ other .....

YOUR PREVIOUS PREGNANCY - specify in chronological order

Childbirths				Interrupted pregnancy					
Year	Gender	Weight	Type of childbirth*	Year	Abortion	Year	Ectopic pregnancy	Year	Spontaneous abortion

*spontaneous, caesarean section, complications, premature + specify week

CONTRACEPTION

Have you ever used hormonal contraceptives? ◯ yes ◯ no intrauterine device ◯ yes ◯ no

Are you currently using any contraceptives? If yes, please specify .....

Do you regularly take any medications? If yes, please specify .....

Are you allergic to any drugs? If yes, please specify .....

Do you smoke? If yes, how many cigarettes a day? .....

TRANSFUSIONS

Have you ever received a blood transfusion? ◯ yes ◯ no complications ◯ yes ◯ no

DO YOU HAVE PROBLEMS WITH URINE INCONTINENCE?

- when coughing, laughing, lifting objects ◯ yes ◯ no
- only a frequent urge to urinate ◯ yes ◯ no

Are you interested in urodynamic examination? ◯ yes ◯ no

MENSTRUAL CYCLE

You had your first menstruation at the age of ..... years, with an interval of about ..... days and lasting about ..... days.

Specify: They are very painful ◯ yes ◯ no They are very strong ◯ yes ◯ no

Your last menstruation started: .....

Approximate date of your last preventative examination: .....

Previous gynaecological care (physician): .....

How did you learn about our clinic? .....

Your current complaints, reason for your visit .....

Do you wish a nurse is present at your examination?

◯ definitely yes ◯ definitely no ◯ rather yes ◯ rather no ◯ I do not care

Date: ..... **Patient's signature** .....

Please note that presence of a nurse is necessary in some examinations. If you ever think the presence of a nurse is undesirable in th
G-CENTRUM Olomouc, s.r.o. undertakes to keep all data strictly confidential and in accordance with the Personal Data Protection Ac
as amended.

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