PROFIGYN

Patient Health Questionnaire:

Name, Surname:

Occupation:

Height, weight:

Family history: Please indicate if any serious illnesses are in your immediate family (your parents, siblings, children):

Especially: malignant tumors, thrombosis, embolism, diabetes, birth defects

Personal History: Have you had any serious or chronic illness and treatment? Are you taking any medications? Do you have any allergies? Have you undergone surgery? Have you had any other traumas, thrombosis, embolisms?

Please write the year of the illness or procedure, and any related medications.

Gynecological History:

Menstruation – When did you first menstruate? When did you last (menopause)?:

Pregnancy, birth, abortion, miscarriage – Please indicate the event/year and any complications. Include the birth weight/height of your child(ren), whether you breast-fed and for how long.

Have you received the HPV vaccine? If yes, please write the name and year of the last dose.

Are you taking any birth control or other hormonal medication? If yes, please state which.

Have you ever been treated for any sexually transmitted disease? If yes, please state which, and what year.

Have you had a breast exam or mammogram? If yes, please state when and with what result.

Thank you very much. Please sign this form to confirm that everything written here is truthful to the best of your knowledge, so that we can best take care of you. If there are any changes, please tell us at your next visit.

I hereby confirm that I have not knowingly concealed any facts about my state of health and I acknowledge that it is in my best interest to update data on my state of health and report any changes to my attending physician or nurse.

Date:

Signature: