

Medical history – gynecologist’s practice Dr. Axel Widing

name: first name.....

birth name:..... date of birth:.....

Have you ever had any previous diseases? (e.g. with heart, lung, liver, kidney etc.)
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Do you have any chronic illnesses? (e.g. asthma, rheumatism, diabetes)
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As a child, have you had any recurrent diseases? (e.g. tonsillitis, teeth problems, inflammation of the bladder, headache etc.)
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Are there any common illnesses in the family? (such as heart attacks, strokes, thrombosis, cancer etc.)
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Are you on any permanent medication? If so, which and in what dosis?
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Do you have any allergies? (e.g. against some kind of medicine)
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Have you ever had surgery on your abdomen?
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Have you ever had surgery at all? (If so, on which organ or body part?)
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Are there any malformations of your genital known?
.....

Do you have children? If yes, in which years were the childbirths?

Were there any complications during birth? Are your children healthy?

Do you have a job? If yes, what do you do for a living?

Is your menstruation on a regular basis? What are the intervals?

Are you in any pain, especially before your menstruations starts? (e.g. a feeling of tension in your breast, mood swings or watery retentions?
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Are you in any pain at the moment? If so, what pain?

Do you prefer herbal medicine? How did you get aware of my practice?