



## New patient record

Title, name and surname: \_\_\_\_\_  
 Marital status: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Address: \_\_\_\_\_ Zip code: \_\_\_\_\_ Insurance company: \_\_\_\_\_  
 Weight (in kilograms): \_\_\_\_\_ Height (in centimeters): \_\_\_\_\_

**Family anamnesis** – has any of these occurred in someone close to you or in your relatives disease? (if yes, tick and state who)

- |  |   |
|--|---|
| <input type="checkbox"/> high blood pressure _____         | <input type="checkbox"/> heart disease kidney _____ |
| <input type="checkbox"/> diabetes _____                    | <input type="checkbox"/> disease _____              |
| <input type="checkbox"/> stroke _____                      | <input type="checkbox"/> thrombosis, embolism _____ |
| <input type="checkbox"/> blood coagulation disorders _____ | <input type="checkbox"/> thyroid disease _____      |
| <input type="checkbox"/> breast _____                      | <input type="checkbox"/> uterine tumor _____        |
| <input type="checkbox"/> cancer ovarian cancer _____       | <input type="checkbox"/> birth defects _____        |
| <input type="checkbox"/> other cancer _____                |   |

**Personal history** - have you ever been treated for the following problems? (if yes, tick, complete)

- |   |   |
|---|---|
| <input type="checkbox"/> frequent or severe headaches                       | <input type="checkbox"/> breast disease                         |
| <input type="checkbox"/> high blood pressure                                | <input type="checkbox"/> gallbladder disease                    |
| <input type="checkbox"/> heart disease                                      | <input type="checkbox"/> phlebitis                              |
| <input type="checkbox"/> thyroid disease                                    | <input type="checkbox"/> thrombosis, embolism                   |
| <input type="checkbox"/> asthma, chronic bronchitis,                        | <input type="checkbox"/> recurrent urinary tract infections     |
| <input type="checkbox"/> epilepsy   | <input type="checkbox"/> high level of blood fats (cholesterol) |
| <input type="checkbox"/> diabetes   | <input type="checkbox"/> blood clotting disorders               |
| <input type="checkbox"/> kidney disease                                     | <input type="checkbox"/> anemia                                 |
| <input type="checkbox"/> liver disease (infectious jaundice, mononucleosis) |   |
| <input type="checkbox"/> cancer   |   |
| <input type="checkbox"/> other more serious                                 |   |
| <input type="checkbox"/> illnesses injuries                                 |   |

**Do you take any medications regularly?** (write what) \_\_\_\_\_

**Allergies:** Are you allergic to any substances? (write on which) \_\_\_\_\_

**Transfusion:** Have you ever received a blood transfusion?  Yes  No  
 Complications after transfusion?  Yes  No

**Do you smoke**  yes How many cigarettes a day? \_\_\_\_\_  No

**TURN AROUND! !**

**Have you had any surgeries? – list in chronological order**

Year	Type of operation	Hospital	Possible complications

**Your previous pregnancies - list in chronological order**

	Year of birth	Gender	Birth weight	Childbirth (spontaneous, caesarean section, complications, premature - write in which week)
1.				
2.				
3.				
4.				
5.				

**Have you had an abortion?**

yes (in numbers how many)  no

**Did you have a miscarriage?**

yes (in numbers how many)  no

**Have you been vaccinated against cervical cancer?**

Yes  No

**Contraception**

Have you ever used hormonal contraception?

Yes  No

Did you have an intrauterine device inserted?

Yes  No

Are you currently using any contraception? (write which one) \_\_\_\_\_

**Do you ever have problems with urine leakage?** (when coughing, laughing, lifting weights)

Yes  No

You get your **periods** from \_\_\_\_\_ years, about \_\_\_\_\_ days and last about \_\_\_\_\_ days. (fill in)

Are they significantly painful?  Yes  No

Very strong?  Yes  No

Have the last periods started? \_\_\_\_\_ (fill in)

**Gynecological treatment**

- |  |  |
|--|--|
| <input type="checkbox"/> ovarian cysts   | <input type="checkbox"/> infertility treatment |
| <input type="checkbox"/> repeated discharges deep gynecological                      | <input type="checkbox"/> inflammation with     |
| <input type="checkbox"/> hormonal treatment of cycle                                 | <input type="checkbox"/> temperatures          |
| <input type="checkbox"/> irregularity procedures for irregular bleeding (scratching) | treatment of the cervix                        |

**Approximate date of last gynecological preventive examination:** \_\_\_\_\_

**Previous gynecological care:** \_\_\_\_\_

**How did you find out about our workplace?** \_\_\_\_\_

Please note that the presence of a nurse is necessary for some examinations. If at any time in the future you feel that the presence of a nurse is desirable, please tell the doctor.

I agree to the processing of my personal and health data for the purpose of providing healthcare, maintaining medical documentation and necessary administration. All in accordance with the GDPR regulation.

I agree

I agree to the sending of news and information (newsletter) to the e-mail address I have provided. (Eg. information about new services, free dates or professional articles.)

I agree

In Ústí nad Labem / In Krupka, dne \_\_\_\_\_

Signature \_\_\_\_\_