Welcome - to get to know you better, we would like to ask you to answer a few questions in advance. You are also welcome to fill out the form at home with the help of your parents and bring it with you to the interview.

If you do not wish to answer a question, simply leave it unanswered. Of course, all information is subject to medical confidentiality (and this also applies to your parents).

Thank you very much! Your practice team

Name: ………………………………………...…….. First name: ……………..……..………………………..

Date of birth: …………………………………….

Parents names: ……………………………………………………………………………………………...

School / Education: …………………………………………………………………………………...

Hobbies: ……………………………………………………………………………………………………

Who is your pediatrician and/or family doctor?……………………………………………………………

Have you been vacinated (please bring along your **vaccination booklet**)?

Mumps, Mesels, Rubella	☐ vaccinated	☐ gone through
Chickebox (Varicella)	☐ vaccinated	☐ gone through
Whooping cough (Pertussis)	☐ vaccinated	
Lockjaw (Tetanus)	☐ vaccinated	
Polio	☐ vaccinated	
Jaundice (Hepatitis B)	☐ vaccinated	
Cervical Cancer (HPV)	☐ vaccinated	

Do you have any allergies?

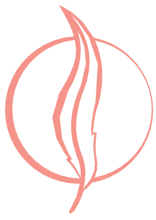
☐ none ☐ Latex
☐ Medication ☐ Contrast Medium
☐ Hay fever ☐ others: ....

Do you take medication regularly?

☐ No ☐ Yes, namely: ....

Do you have or have had certain illnesses?

☐ No
☐ Thyroid disfunction ☐ Diabetes ☐ High blood pressure
☐ Thrombosis (Blood clot) ☐ Pulmonary embolism ☐ Varices (varicose veins)
☐ Migraine ☐ others, namely: ....



Have you had surgery? ☐ No
☐ Scraping/Curettage: when? .... ☐ Ovarian surgery: when? ....
☐ Breast surgery: when? .... ☐ Appendix: when? ....
☐ Others: when and what? ....

Are you smoking? ☐ No ☐ Yes: how much per day? ....
Trinkst Du regelmässig Alkohol? ☐ No ☐ Yes: how much per day?....................
Nimmst Du Drogen? ☐ No ☐ Yes: what kind? ....

Are there any serious illnesses in your family? ☐ No
☐ Stroke: who…….. ☐ Heart attack: who ....
☐ Thrombosis: who .... ☐ Pulmonary embolism: who ....
☐ Diabetes: who .... ☐ Breast Cancer:who...
☐ Abdominal Cancer: who ....
☐ Other types of cancer: who and what ....
☐ Congenital malformations: who and what…… ....
☐ Chromosomal disorders (e.g. Down syndrome): who and what ....

How old were you when you had your first period? .... years old.

When war your last period? (Date of the 1st of bleeding): … … … ……………………………………..

How is your period?
☐ strong ☐ medium ☐ weak
☐ somewhat painful ☐ very painful
☐ regular: interval between 2 bleedings (start to start)………… days
☐ irregular: longest and shortest cycle:…………days ………… days
Duration of bleeding: approx.. ....days

Did you already have sexual intercourse?
☐ No ☐ Yes – How old were you the first time?.........................years old

Do you use contraception?
☐ No
☐ Condoms ☐ Vaginal ring ☐ Patch ☐ Pill, Name: ……………………………….
☐ Implanon ☐ IUD with / without hormone

Have you ever been pregnant?
☐ No ☐ Yes

Do you have any complaints at the moment?
☐ No ☐ Yes, which ones? …………………………………………………………………….

And most importantly: What questions do you have for us? What would you like to talk about?
☐ Period ☐ Contraception
☐ Vaccination against cervical cancer ☐ Other questions: ……………………………………..