Frauenarztpraxis
Dr. med. Hans-Christoph Kübler

Franz-Knauff-Str. 24, 69115 Heidelberg, Tel: 06221/22481

Thank you for your interest in our doctors surgery!

You have made your first appointment with us. Should you have records of any previous medical treatments, please bring them with you.

Please accurately complete the front and reverse sides of our admission form and bring it with you to your firtst appointment. As well as your personal details, we need to have information about your general state of health in ordert o conduct a thorough clinical diagnosis and recommend a risk-free treatment. All your data is subject to medical confidentiality.

Our surgery is located in Heidelbergs´s Weststadt. We have enclosed directions of how to find us, parking options as well as the confirmation of your first appointment.

Admission Form and Medical History

Patient	**Main Person Insured**
Name _____	**Name** _____
First Name (s) _____	**First Name (s)** _____
Birthdate _____	**Birthdate** _____
Postcode, Place of Residence _____	**Postcode, Place of Residence** _____
Street _____ **No.**____	**Street** _____ **No.**___
Tel._____**Mobile** _____	**Tel.** _____ **Mobile** _____
Email _____	**Occupation** _____
Occupation _____	

General Practitioner: _____ **Do you wish for a medical report tob e sent to your GP**

- ○ **Ja**
- ○ **Nein**
- ○ **Send only if diagnosis Suggests condition**

Employer _____

Health Insurance _____ ○ **Compulsory Insurance** ○ **Voluntary Insurance**

○ **Eligible for Benefit** ○ **Private Supplementary Insurace**

Privately Insured _____ **Basic Tariff** ○ **Yes** ○ **No**

Who gave you a recommendation for this surgery? _____

_____

At what age did you have your first period: .....

Menstruation: Duration of period: ..... Painful period? ○ **yes** ○ **no**

Irregular period? ○ **yes** ○ **no**

How many tampons or sanitary towels do you need per day? .....

Contraception (e.g. the pill, coil etc.): ○ **yes** ○ **no**

(if yes) please give details: _____

since when: _____

Pregnancies (including miscarriages): _____ **Births:** _____

Do you take any medication on a regular basis? ○ **yes** ○ **no**

(if yes) : please give details _____

Do you smoke?: ○ **yes** ○ **no**

Have you ever had thrombosis or an embolism? ○ **yes** ○ **no**

Alternarively, a family member? ○ **yes** ○ **no**

Do you suffer from allergies? ○ **yes** ○ **no**

(if yes) : please give details: _____

Do you have any medical preconditions? ○ **yes** ○ **no**

(if yes) : please give details: _____

Are there any cases of cancer in your family ○ **yes** ○ **no**

(wenn ja) welche: _____

Have you had any surgical procedures, in particular relating to your breasts or genitalia? ○ **yes** ○ **no**

(if yes) : please give details: _____

Have you ever had a mammography? ○ **yes** ○ **no**

(if yes) : please give details: when: _____ **where:** _____

Many Thanks for your help **Ihr Praxisteam**