

Anmelde- und Anamnesebogen

Surname _____

First Name _____

Date of Birth _____

Postcode/Place of Residence _____

Street _____ No. _____

Phone. _____ Mobile _____

Email: _____

Career _____

Last menstruation:

Menstruation: bleeding time:..... painful bleeding? yes no

Irregular bleeding? yes no

How many tampons/pads do you use per day?

Contraception (z.B. contraceptive pill, IUD etc.): yes no

Method of contraception: _____

since: _____

Pregnancies (also miscarriage): Birth:

Do you take medication regularly? yes no

If so, which? _____

Do you smoke? yes no

Have you already had a thrombosis or embolism? yes no

Or a family member of yours ? yes no

Do you suffer from allergies? yes no

If so, which? _____
