LMU KLINIKUM
Department of Obstetrics and Gynaecology
Director and Chair: Prof. Dr. med. Sven Mahner

Medical History, Addresses, Information questionnaire

(FB-Patient Questionnaire)

(Barcode-Label)

Dear patient,
welcome to the LMU Department of Obstetrics and Gynecology!

Every day, we consult more than 250 outpatients in various general and specialist medical issues. In addition to scheduled appointments, our team handles emergencies as well as all gynecological and obstetric issues (consultations) for the entire LMU University Hospital.

Our aim is to provide you with the best medical and personal care. At the same time, we strive to keep the waiting time for individual patients as short as possible. However, there can be unforeseeably high numbers of patients during our consultation hours or unscheduled, time-consuming emergency consultations and examinations, meaning that a waiting period cannot always be avoided.

As not all patients are waiting for the same consultation, patients who arrive after you may be treated before you. In exceptional cases, urgent cases may also be prioritized.

To make your examination and medical consultation as effective as possible and thus reduce the waiting time, we have the following requests for you:

- If you have any relevant findings for your consultation, please hand them in at the nurse registration.
- Please also hand in any QR-Codes, CDs or USB sticks with X-ray/CT/MRI images you have brought with you at the nurse registration so that they can be scanned and uploaded to our system.
- Our consultation language is German or English, if you do not speak these languages, please bring a translator to the appointment.
- Please make an appointment for every visit to our outpatient clinic – including laboratory tests - to reduce waiting times.
- Please complete this questionnaire as thoroughly as possible.

With best wishes

Sven Mahner

Prof. Dr. med. Sven Mahner
Director and Chair of the Department of Obstetrics and Gynaecology

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To speed up the organizational process, we kindly ask you to fill out this questionnaire:

Referring doctor

Name	Telephone	Information transfer
		☐ yes ☐ no

Other external doctors involved in treatment

Name	Telephone	Information transfer
gynaecologist (if not referring physician):		☐ yes ☐ no
family doctor:		☐ yes ☐ no
mammography screening center:		☐ yes ☐ no
		☐ yes ☐ no
		☐ yes ☐ no

The following persons may receive information about my health

Name	Telephone	Information
		☐ yes ☐ no
		☐ yes ☐ no

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In case of surgery, please call the following person postoperatively:

Name	Telephone	Information
		☐ yes ☐ no

I can be reached as followed:

Telephone: _____ Mobile: _____

E-Mail: _____

1. Questions about medical history

What is the main reason for your appointment?

_____

Do you have any known pre-existing conditions such as?

☐ yes ☐ no high blood pressure

☐ yes ☐ no diabetes

☐ yes ☐ no heart diseases (e.g., heart attack, heart failure, atrial fibrillation)

☐ yes ☐ no respiratory diseases (e.g., bronchial asthma, COPD)

☐ yes ☐ no thyroid diseases

☐ yes ☐ no nervous diseases

☐ yes ☐ no thrombosis, embolism (blood clots in blood vessels, stroke)

☐ yes ☐ no blood clotting disorders (e.g., tendency to bruises, heavy menstrual bleeding. etc.)

☐ yes ☐ no diseases of the muskuloskeletal system

☐ yes ☐ no kidney and urinary tract diseases

☐ yes ☐ no infectious diseases (e.g. HIV/hepatitis)

☐ yes ☐ no other diseases:

_____

_____

_____

_____

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Do you have any known allergies?

☐ no ☐ yes: to medication:

to other:

Type of allergic reaction (e.g., skin rash, shortness of breath, incidental finding during allergy test, etc.):

Do you have an allergy passport? ☐ yes ☐ no

What medication are you taking, in what dose and at what time of day?

(e.g. 10 mg in the morning and 5 mg in the evening)

Medication	Dose	Dosing schedule

Medication	Dose	Dosing schedule

Are you taking blood-thinning medication? ☐ yes ☐ no
(e. g. Aspirin, Warfarin or other anticoagulants)

Have you ever had surgery? ☐ yes ☐ no
If so, what was done, when was it done, why and where?

Date	Surgery	Hospital

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How tall are you? _____ cm

How much do you weigh? _____ kg

Do you smoke? ☐ No, I have never smoked.

☐ Yes, I smoke _____ cigarettes on average per day for _____ years.

☐ Not anymore. I last smoked _____ and smoked an average of _____ cigarettes per day for a total of _____ years.

2. Gynaecological History

When was the first day of your last menstrual period? _____._____._____ (or year)

Cycle length (1st day of bleeding to 1st day of the next bleeding) _____ days

How many days does the menstrual period last? _____ days

Were there any cycle abnormalities? _____

Are you currently pregnant?

☐ no

☐ yes: Have you ever had an ultrasound scan during this pregnancy?
☐ yes ☐ no

Could the pregnancy already be seen in the uterus during the ultrasound scan?
☐ yes ☐ no

Has a heartbeat ever been seen on ultrasound during this pregnancy?
☐ yes ☐ no

What date of birth was calculated (on the basis of the ultrasound scan)?

How many times have you been pregnant? _____ times; including:

Vaginal births: _____ Miscarriages/abortions: _____

Caesarean sections: _____ Ectopic Pregnancies: _____

When was your last cancer screening with a Pap smear? _____

Result ☐ normal ☐ abnormal: _____

Have you ever had a mammography?

☐ no

☐ yes: most recent date:

in the following facility:

Result/findings: ☐ normal ☐ abnormal

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Do you have a family history of cancer?

☐ no	☐ yes:	Relative (maternal/paternal side, if applicable)	Type of cancer	Age at initial diagnosis

Do you have an advance directive ☐ yes ☐ no

Do you have children?

☐ I have no children

☐ I have given birth to _____ child/children (see above under pregnancies)

☐ I have _____ non-biological child/children

3. Are there any other medical conditions or details we should be aware of?

4. Feedback

How did you hear about us?

Do you have any feedback, suggestions, or recommendations?

Thank you very much!!

Date/signature (patient)

Date/signature (doctor)