Szent Anna Gynaecological Surgery – Dr. Zatik János

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Detailed Gynaecological Data Sheet

Name: Date of birth:

Postal address:

Phone: TAJ or passport number: Marital status:

E-mail address: Occupation:

Do you have drug allergy?

I don't know Yes, to these drugs:

Do you smoke? Do you drink alcohol? Dou you have addictive drugs?

Pregnancy history

Total pregnancies: Previous Caesarean sections: Spontaneous births: Vacuum births:

Live term births (how many, weights): Premature births (how many, weights):

Miscarriages (how many, weeks): Abortions (how many, weeks):

Stillbirths (how many, weeks): Ectopic pregnancies (how many):

Operations, surgical interventions **Blood type** (if you know):

Have you ever had any surgeries?

No Yes (what kind of and when):

Have you ever suffered from illnesses below? (or someone in your family)

	You		Your family	What relation is he to you?
Heart disease	No	Yes	No	Yes
Blood clots, stroke, thrombosis	No	Yes	No	Yes
Hypertension	No	Yes	No	Yes
Diabetes	No	Yes	No	Yes
Anaemia	No	Yes	No	Yes
Kidney disease	No	Yes	No	Yes
Genetic disease	No	Yes	No	Yes
Mental illness	No	Yes	No	Yes
Hypothyroidism	No	Yes	No	Yes
Infertility	No	Yes	No	Yes
Epilepsy, convulsion	No	Yes	No	Yes
Cancer	No	Yes	No	Yes

Have you ever been treated with these illnesses, or have you ever had any of them?

Herpes	No	Yes (in this year):	
Gonorrhea	No	Yes (in this year):	
Chlamydia	No	Yes (in this year):	
Syphilis	No	Yes (in this year):	
Trichomonas	No	Yes (in this year):	
Vaginitis	No	Yes (in this year):	
Condyloma – Genital warts	No	Yes (in this year):	HPV type:

Menstruation details

Duration of flow (days)? Cycle: Concomitant circumstances:

Bleeding intensity: What do you use? Pantyliner Tampon Other:

Year of the first menstruation: Date of the last menstruation:

Sexual life

Dou you have sexual partner? No Yes Since from? Sexual contacts per month:

Date of the first sexual contact: Last sexual actus: Number of your previous partners:

Contraceptive method: Previous contraceptive method:

Have you ever been sexually abused? Yes No

Was the first sexual contact painful? Yes No

Complains, symptoms

Vaginal problems:

Breast problems:

Urination problems:

Sexual problems:

Previous treatments for problems above:

Date of last cancer screening and result:

Date of last mammogram and result:

What kind of vitamins, medicinal herbs do you have?

Reason you come:	Gynaecologist examination		First examination	Cancer screening	Pain
Contraception	Infection	Vaginal leaking	Annual check	Pregnancy diagnosis	Ultrasonic
Prenatal care	Infertility	Breast examination	Consultation	Sexual consulting	

Your data is kept confidential. If you don't want third party to be present during the consultation, indicate it in advance.
You can write some other important information to the following lines. Thanks for filling out the form, helping our work with it.