KLINIKA PROMIENISTA

L/001/06

First name ..... Second name .....

Address..... ID card .....

Insurance Policy No..... Mobile/e-mail: .....

We assure that information in this form is confidential and belong to medical documentation

Please answer the following questions as precisely as possible; put down „yes, no or I don't know" where relevant

Do you have any of the following diseases:				
1	Smallpox	☐ Yes	☐ No	☐ I don't know

2	Measles	☐ Yes	☐ No	☐ I don't know
3	Rubella	☐ Yes	☐ No	☐ I don't know
4	Mumps	☐ Yes	☐ No	☐ I don't know
5	Heart diseases (e.g. heart attack, chest pain, myocardits, arythmia, congenital heart defect, breathing difficulty), other ……	☐ Yes	☐ No	☐ I don't know
6	Circulatory problems (e.g. hypertension, low pressure, fatigue, faint) other …..	☐ Yes	☐ No	☐ I don't know
7	Allergies (e.g. to antibiotics, food, blisters, iodine, pollen) other …….	☐ Yes	☐ No	☐ I don't know
8	Lung and respiratory diseases (e.g. tuberculosis, asthma chronic bronchitis, chronic coughing) other ……	☐ Yes	☐ No	☐ I don't know
9	Vessels diseases (e.g. varicose, trombophlebitis, limbs ischemia) other …….	☐ Yes	☐ No	☐ I don't know

10	Muscle diseases (miastenia). Is anyone from your family suffering from such diseases ?	☐ Yes	☐ No	☐ I don't know
11	Neurological diseases (e.g. epilepsy, sclerosis multiplex, loss of consciousness, stroke, paralysis) other	☐ Yes	☐ No	☐ I don't know
12	Stomach problems (e.g. ulcer, gastritis) other	☐ Yes	☐ No	☐ I don't know
13	Liver problems (e.g. hepatitis, cirrhiosis, gall stones) other	☐ Yes	☐ No	☐ I don't know
14	Metabolic disorder (e.g. diabetes, gout) other	☐ Yes	☐ No	☐ I don't know
15	Thyroid gland diseases (e.g. hypothyreosis, hyperthyreosis) other	☐ Yes	☐ No	☐ I don't know
16	Urological diseases (e.g. kidneys infection, kidneys stones) other	☐ Yes	☐ No	☐ I don't know
17	Bone and joint problems (e.g. discopathy, rheumatic diseases, arthritis) other	☐ Yes	☐ No	☐ I don't know

18	Blood diseases and coagulations problems (e.g. haemophilia, easy bruising, spontanens nose bleeding) other	☐ Yes	☐ No	☐ I don't know
19	Eyes problems (e.g. glaucome, cataract, miopia more then 5 dioptries)	☐ Yes	☐ Yes	☐ I don't know
20	Psychological problems ? (depression or other).....	☐ Yes	☐ Yes	☐ I don't know
21	Do you suffer from other diseases ? If yes, please put down the name of a disease		☐ Yes	☐ I don't know
22	Did you loose more than 5% of your normal weight during last 6 months?		☐ Yes	☐ I don't know
23	Do you smoke ? How many cigarettes a day ? ..... How long ?		☐ Yes	☐ No
24	Do you drink ? How many drinks a week ? ..... How long ?		☐ Yes	☐ No
25	Are you used to use any psychoactive substances ?		☐	☐ No

			Yes	
25	Did anyone in your family suffer from a cancer ?	☐ Yes. Who ? What kind of cancer ?	☐ No	☐ I don't know

OPERATIONS:			
Did you have a surgery in the past? ☐ No	☐ Yes	date	Scope of the operation ....
		date	Scope of the operation ....
		date	Scope of the operation ....
Did you have a <u>minor</u> operation in the past ?	☐ Yes	date	Scope of the operation ....
		date	Scope of the operation .....

☐ No			....
		date	Scope of the operation ....

First period:	Age:	Indicated by medicines ☐ Yes ☐ No

CYCLES (counting from the first day of menstruation till the first day of the next one)		
Regular ☐ Yes ☐ No	The shortest: number of days	The longest: number of days .....

Duration of menstruation (bleeding) number of days:					
Intensity (scale 1-5)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

REGULAR SUFFERING:		
Painfull menstruation	☐ Yes	☐ No
Painfull first day of bleeding	☐ Yes	☐ No
Pain during whole time of bleeding	☐ Yes	☐ No
Pain during cycles	☐ Yes	☐ No
Spotting before menstruation	☐ Yes	☐ No

Spotting during cycles	☐ Yes	☐ No
Intercourse spotting	☐ Yes	☐ No
RECENT PERIOD (date)	FINAL PERIOD (date)	
Was the recent period as usual?	☐ Yes	☐ No
After a break ?	☐ Yes	☐ No

MEDICATIONS:			
Long lasting treatment ?	☐ No	☐ Yes	☐ What kind .....
Contraception?	☐ No	☐ Yes	☐ What kind .....
Hormonal treatment ?	☐ No	☐ Yes	☐ What kind .....
Hormonal replacement therapy ?	☐ No	☐ Yes	☐ What kind .....
Other medications ?	☐ No	☐ Yes	☐ What kind .....

BIRTHS:					
Have you ever delivered?		☐ Yes		☐ No	
Year ……	☐ Son ☐ Daughter ☐ weight ……	☐ natural delivery ☐ vacum ☐ cesarian section	week of pregnancy ……	alive: ☐ Yes ☐ No	Complications ☐ No ☐ Yes ……
Year ……	☐ Son ☐ Daughter ☐ weight ……	☐ natural delivery ☐ vacum ☐ cesarian section	week of pregnancy ……	alive: ☐ Yes ☐ No	Complications ☐ No ☐ Yes ……
Year ……	☐ Son ☐ Daughter ☐ weight ……	☐ natural delivery ☐ vacum ☐ cesarian section	week of pregnancy ……	alive: ☐ Yes ☐ No	Complications ☐ No ☐ Yes ……
Miscarriages		☐ Yes		☐ No	

Year ……	Week of pregnancy ……	☐ Miscarriage	☐ Abortion
Year ……	Week of pregnancy ……	☐ Miscarriage	☐ Abortion
Year ……	Week of pregnancy ……	☐ Miscarriage	☐ Abortion
TESTES			
Last PAP – Smear / Bethesda Smear		When …… Result……..	
Have you ever had uncorrect one?		☐ Yes. When? ……	☐ No
Have you ever been HPV vaccinated ?		☐ Yes. When ? ……	☐ No
Have you ever had a mammography?	☐ No	☐ Yes. When? …….	Result: ……

All the above information is true and correct. I don't keep any of information concerning my health in a secret.

…… ……

signature *THANK YOU* date