

Questionnnaire – Social Freezing							
Surname: Date of birth First name:							
Address:							
Telephone Nr. Private: Mobile: Business:							
edical Insurance Occupation:							
Gynaecologist	Email address:						
Appointed day Appointed time							
1. When did you have your first period?	at approx years of age						
2. When did your breasts start to develop?	at approx years of age						
3. Have you ever had regular periods without taking hormone supplements (e.g. the Pill)?							
4. Are your periods regular and how many days are there from day 1 of a period till day 1 of the next cycle without taking medication?							
	days						
 □ irregular between □ I haven't had a period for 	days/weeks/months weeks/months/years						
5. How many days on average does your period last?							
Have you had bleeding between your periods (intermenstrual bleeding)?							
	□ no □ yes						
If yes, when does the intermenstrual bleeding take place	e arly in the cycle						
6. Have you had any problems with your breasts?	□ no □ yes						
If yes, what type?tr	reatment						
7. Have you been pregnant before?	□ no □ yes						
8. Have you experienced problems in previous pregnancies							
 Problems with the development of the placenta Fever/ inflammation after the birth/ abortion or miscarriage 							
9. Did you or do you have any pelvic disorders?	□ no □ if yes						
□ Ovarian cysts							
Endometriosis							
 Fibroids (Myomata) 							
 Pelvic infection (Salpingitis) 							
 Blocked tubes (Hydrosalpingx) 							
In which year							
How were you treated (medication/ operation)?							

10. Does your we	ight remain con	stant or does it te	end to fluctuate (mo	re than 4 kg or	[∙] ½ stone)?
 remains constant mostly increases mostly decreases 		ends to fluctuates	Your heigh	ghtcm	
		Your weightkg			
11. Last Pap smear	· (cervical test fe	or cancer)/			
Result:	normal		abnormal		
12. Have you taken	hormone supp	lements e.g. the ∣	Pill?		
		□ yes	□ no if	yes,	
Medication	from	to	Medication		to
13. Have you suff			2 □ none		
□ Thyroid disorder		□ Dia	betes	□ Adrena	al gland disease
□ Thrombosis/Embolism □ Migraine		Kidney	Kidney disease		
Cardiovascular	disease/Hyperter	nsion 🗆 Epi	leptic fits	Liver d	lisease
□ Varicose veins □ Cancer/ Tumours		Mental	Mental disorders		
Asthma/ Chronic	c bronchitis	□ Ga	stro-intestinal illness	Infecti	ous diseases
D Other					
15. Are you allergic	to any medicat	tion or substance	□ no for what? r what? s? □ no		
16. Do you smoke?		1-5 Cig/day	□ 5-15 Cig/day	□ more, a	approxday
17. Have any of the	following cond	itions been diagn	osed in a blood rela	ative in your fa	mily?□ no
Thrombosis	U	nwanted childlessr	iess	Cancer	
Inherited disea	ases(eg cystic	fibrosis, Muscular	dystrophy		
□ Other					
18. Are you inocula	ited against her	oatitis B? □ no	if yes, when last?.		
19. How did you be	come aware of	our practice?			
On recomment	dation/ Referral	from Doctor (Name	:		
 On recomment 	dation of a friend	1			
Information from	om the telephone	book			
	om the internet				
Other					

04 Empfang/03 Formulare/Interne Formulare mit Pat.-Kontakt/Fragebogen Social Freezing englisch, Formular-Nr. 26, Version 02/03-2016