Gynaecology Practice
Drs. Behrens, Hammel

eizellbank erlangen

Questionnnaire – Social Freezing

Surname: …… First name: ……. Date of birth……

Address: ……

Telephone Nr. Private: ……. Mobile: ……. Business: ……..

Email address ……. Occupation: ……

Gynaecologist ……... Medical insurance: …….

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) ?

□ yes □ no

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?

□ regular between ……..and ……...days
□ irregular between …….....and ……days/weeks/months
□ I haven't had a period for ..…….
weeks/months/years

5. How many days on average does your period last? …….days

Have you had bleeding between your periods (intermenstrual bleeding)?

□ no □ yes

If yes, when does the intermenstrual bleeding take place □ early in the cycle
□ later in the cycle

6. Have you had any problems with your breasts? □ no □ yes

If yes, what type? ..... treatment …….

7. Have you been pregnant before? □ no □ yes

……

……

8. Have you experienced problems in previous pregnancies □ no

□ 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 weight remain constant or does it tend to fluctuate (more than 4 kg or ½ stone)?

□ remains constant □ tends to fluctuates Your height ……cm

□ mostly increases □ mostly decreases Your weight ……kg

11. Last Pap smear (cervical test for cancer)……./…….

Result: □ normal □ abnormal

12. Have you taken hormone supplements e.g. the Pill?

□ yes □ no if yes,

Medication from to Medication from to

1…… 2……

13. Have you suffered from any of the following? □ none

□ Thyroid disorder □ Diabetes □ Adrenal gland disease

□ Thrombosis/Embolism □ Migraine □ Kidney disease

□ Cardiovascular disease/Hypertension □ Epileptic fits □ Liver disease

□ Varicose veins □ Cancer/ Tumours □ Mental disorders

□ Asthma/ Chronic bronchitis □ Gastro-intestinal illness □ Infectious diseases

□ Other……..

14. Do you regularly take any medication? □ no

If yes, name ……. ... …… for what?……

……. for what?……

15. Are you allergic to any medication or substances? □ no

yes, to……

16. Do you smoke? □ no □ 1-5 Cig/day □ 5-15 Cig/day □ more, approx….day

17. Have any of the following conditions been diagnosed in a blood relative in your family? □ no

□ Thrombosis Unwanted childlessness Cancer

□ Inherited diseases (eg cystic fibrosis, Muscular dystrophy

□ Other…….

18. Are you inoculated against hepatitis B? □ no if yes, when last?.....

19. How did you become aware of our practice?

□ On recommendation/ Referral from Doctor (Name:……

□ On recommendation of a friend

□ Information from the telephone book

□ Information from the internet

Other……