DYSPLASIE
DIAGNOSTIK
DOKOUPIL

DKG
KREBSGESELLSCHAFT

name:		**date of birth:**	
address:		**body height (cm):**	
		weight (kg):	
phone number:		**profession:**	
e-mail:		**general practitioner:**	

diseases:
- ☐ hypertension
- ☐ diabetes
- ☐ thrombosis / embolism
- ☐ thyroid diseases
- ☐ cardiac infarction
- ☐ allergies: .....
- ☐ others: .....

operations:
- ☐ abdominal hysterectomy
- ☐ breast operations
- ☐ other gynecological operations: .....
- ☐ other operations: .....

family history:
- ☐ stroke
- ☐ hypertension
- ☐ thrombosis / embolism
- ☐ cancer (which type and who?): .....

births: number: .....

1. child:	☐ m ☐ f	☐ standard birth	☐ ventouse / forceps	☐ cesarean
2. child:	☐ m ☐ f	☐ standard birth	☐ ventouse / forceps	☐ cesarean
3. child:	☐ m ☐ f	☐ standard birth	☐ ventouse / forceps	☐ cesarean

complications during pregnancy / birth: .....
abortions (number): ..... induced abortions (number): .....

medicaments:
contraceptive pill (name): .....
hormones (name): .....

loop:
- ☐ copper loop
- ☐ copper coil
- ☐ copper pearl ball
- ☐ Mirena
- ☐ Kyleena
- ☐ Jaydess

since: .....

others: .....

HPV – vaccination: ☐ yes ☐ no ☐ unknown
smoker: ☐ yes ☐ no

menstruation:
age at first menstruation: .....
days of menstruation: .....
female menstrual cycle (first day of bleeding to next): .....
menopause: ☐ yes, since: .....

Consent to data collection, processing and storage:
I hereby consent to the collection, processing and storage of my personal data for the purpose of consultation, examination, treatment and billing by the medical practice. I have understood and taken note of the patient information on data protection of the practice in accordance with the GDPR. I am aware, that I can revoke my consent in whole or in part at every time.

Date, signature: .....

Release from medical confidentiality:
I hereby give my consent for medical reports and findings to be sent to the referring / providing doctor, GP or external partners (e.g. cooperating laboratories) providing further treatment (e.g. e-Doctor's letter). To this end, I release Dysplasie Diagnostik Dokoupil treating me from their duty of medical confidentiality. I also authorize the practice to request the necessary findings from my family doctor, other specialists or clinics.

Date, signature: .....

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