

Medical history questionnaire for contraceptive advice

Dear Patient,

Your health is important to us. In order to give you the best advice on choosing your contraceptive method, please answer the following questions:

Date

Personal details

Surname, first name	Height
Street, house no.	Weight
Postcode, town	BMI*
Date of birth	Blood pressure*

* to be filled in by the doctor's assistant

Questions about your lifestyle

Do you smoke or have you smoked in the past?	Yes	No	If so, how many cigarettes a day?
Do you often take long-haul flights (> 4 hours)?	Yes	No	
Have you recently given birth or are you breast-feeding?	Yes	No	
Do you have an irregular daily routine and find it hard to take medications at the same time each day?	Yes	No	
Do you regularly take any medications or herbal medicines or dietary supplements?	Yes	No	

If so, which ones?

Your methods of contraception to date

My most recent contraception was:	Pill	Hormonal patch	Vaginal ring	3-month injection	Hormonal coil
	Hormone implant/contraceptive rod			Copper coil, copper chain, copper ball	
	Other				
	I have not used any hormonal contraceptives to date		I have not used any contraceptives to date		

How long have you been using your particular method of contraception?

Have any side effects occurred while using it?
If so, which ones?

Information about your periods

Bleeding pattern	Irregular	Regular	Anything else you wish to tell us about your periods (e.g. breast tenderness, headache)?
Breakthrough bleeding	frequent (during every period) rarely (every 2 – 3 periods maximum)	never	
Length of menstrual cycle (days)*	< 24	24 – 34	> 34
Bleeding intensity (sanitary pads or tampons/day)	heavy (> 5)	moderate (2 – 5)	weak (< 2)
Pain before/during your period (abdominal and lower abdominal pain)	Yes, severe	Yes, moderate	None or mild

* Length of menstrual cycle = period of time from the first day of bleeding up to the day before the next monthly bleeding starts.

Questions about existing illnesses

Do you regularly suffer from diarrhoea and/or vomiting? Yes No

Do you suffer from migraine or severe headaches? Yes No

If so: Are these associated with visual or speech disorders and/or numbness? Yes No

Do you suffer from acne? Yes No

Do you suffer from excessive body hair? Yes No

Are you scheduled to undergo major surgery or prolonged immobilisation? Yes No

Do you have any of the following conditions?

High blood pressure	Yes	No	Liver or gallbladder disorders	Yes	No
Blood clotting disorder	Yes	No	Epilepsy	Yes	No
Chronic heart or lung disease	Yes	No	Psychiatric disorders	Yes	No
Angina pectoris / Heart rhythm disorders	Yes	No	Eating disorders	Yes	No
High blood fat levels	Yes	No	Chronic bowel disease	Yes	No
Diabetes mellitus	Yes	No	Varicose veins	Yes	No
Chronic kidney disease	Yes	No			

Do you suffer from any other chronic disease (such as sickle cell anaemia, Crohn's disease, ulcerative colitis)?

Do you have any allergies or intolerances? Yes No

If so, which ones?

Have you ever experienced any of the following events?

Thrombosis and/or lung embolism	Yes	No	Heart attack or stroke	Yes	No
Unexplained black-outs and/or loss of consciousness	Yes	No	Cancer	Yes	No

Other

Have you been diagnosed with endometriosis? Yes No

Have you had any gynaecological surgery in the past? Yes No

If so, which type?

Questions about illnesses in your family

Has a relative (mother, father, siblings, grandparents, children) ever had any of the following illnesses/conditions? If so, who and at what age?

Thrombosis / Lung embolism	Yes	No	Heart disorders	Yes	No
Heart attack	Yes	No	High blood fat levels	Yes	No
Stroke	Yes	No	Cancer	Yes	No



Please add your signature via „Fill & Sign“ or „Add signature“.

Place, date

Signature

As a patient, you hereby confirm that you have completed the questionnaire to the best of your knowledge. This medical history questionnaire is intended as a documentation aid for the doctor and is by no means exhaustive.

Medical notes