Dysplasie-Einheit München
Dr. Weyerstahl und Kolleg*innen

amedes MVZ für Gynäkologie und Pathologie München GmbH

Welcome to our colposkopic clinic!
Beside your name and address we need some information about your state of health.
This is important to find the right treatment for you. All information is subject to medical confidentially.

last name: _____ **first name:** _____ **date of birth:** _____

ZIP/city: _____ **street:** _____

profession: _____ **merital status:** _____

referring doctor: _____ **health insurance:** _____

phone number: _____ **phone number during day:** _____

Email: _____

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childbirths: _____ **mode of delivery:** _____ **desire for children?** _____

permanent relationship? _____ **miscarriages/abortions** _____

birth control? _____ **smoker?** _____ **If yes, how many cigarettes?** _____

age of first menstruation: _____ **date of last menstruation:** _____

surgeries (which / when): _____

_____

health conditions (e.g. heart-circulation, gastrointestinal tract, kidney, skin, infection etc.): _____

_____

Thrombosis / Embolism: _____ **Allergies:** _____

Drugs: _____

Familial disease (e.g. breast cancer): _____

_____

HPV vaccination? **yes** ☐ **no** ☐ **Body height:** _____ **Body weight:** _____

I agree that:

1. my data is circulated to all co-examining and pre-examining doctors and laboratories (sending to the Dysplasie-Einheit)
2. my data is circulated to me in any written or spoken form (letter, e-mail, SMS or telephone call)
3. my data will be stored in form of paper or on any external, secured volume
4. photos are made only in purpose of the treatment
5. photos are made in purpose of further professional education (e.g. for colleagues)

Point 1-4 are necessary for your examination

☐ I agree with all points of 1- 5; ☐ I only agree with points _____

date/ patient signature **Munich,** _____