Personal information – hormones woman

General information

Name ..... E-Mail .....

First name ..... Telephone (day time) .....

Street address ..... Date of birth .....

Postal code and city ..... Profession .....

Our questions for you

Your height ..... Your weight ..... Your age .....

Do you have children? ☐ Yes ☐ No Please provide their birth years .....

Period / monthly cycle ☐ regular: Every ..... days and lasts ..... days ☐ irregular ☐ non-existent: last bleeding (year) .....

Do you have any allergies? ☐ Yes ☐ No

List allergies here .....

Do you take medication? ☐ Yes ☐ No

Please provide the exact name, strength and dosage .....

Have you had an important operation in the past? ☐ Yes ☐ No

List type of operation and date (year) .....

Do you suffer from a serious illness? ☐ Yes ☐ No

List illness(es) here .....

Have any members of your immediate family (mother, sister, aunts) been diagnosed with ovarian or breast cancer? ☐ Yes ☐ No

Please list here .....

Do any of your parents, grandparents or siblings have vascular diseases (heart attack, stroke, thrombosis, dementia)? ☐ Yes ☐ No

Please list here .....

Do you smoke? ☐ Yes ☐ No How many cigarettes per day? .....

Do you suffer from any of the following symptoms:

Depression? ☐ Yes ☐ No Since when? .....

Difficulty sleeping? ☐ Yes ☐ No Since when? .....

Hair loss? ☐ Yes ☐ No Since when? .....

Hot flashes? ☐ Yes ☐ No Since when? .....

Loss of energy / listlessness? ☐ Yes ☐ No Since when? .....

Loss of libido? ☐ Yes ☐ No Since when? .....

Memory loss? ☐ Yes ☐ No Since when? .....

Sweating? ☐ Yes ☐ No Since when? .....

Weight gain or loss? ☐ Yes ☐ No Since when? .....

Your **MAIN ISSUE**? .....

How did you hear about us? ☐ Acquaintances ☐ Book ☐ Internet ☐ Newspaper ☐ Other doctor ☐ Podcast

☐ Radio advertising ☐ Social Media ☐ Other: .....