Dr. Stefan Buballa · Gynecology and Obstetrics FMH

Sub-specialization in Operative Gynecology and Obstetrics

Personal Information:

Family Name (Surname):

First Name:

Height (cm):

Weight (kg):

Please list any allergies you may have

Gynecological History:

How old were you when you had your first menstruation?
When was your last menstruation?
What was the duration in days of your last menstrual cycle?
Are your cycles regular ☐ or irregular ☐ ?

Please list any gynecological surgeries you may have had. Provide dates for each surgery and the name and location of the medical facility where the surgery was performed.

When and where did you receive your last mammogram or breast ultrasound?

What form(s) of contraception do you use?

Have you been vaccinated against cervical cancer? Yes ☐ No ☐

General medical history:

Please list any non–gynecological surgeries you may have had. Provide dates for each surgery and the name and location of the medical facility where the surgery was performed?

Do you have, or have you ever had, any of the following?
Cancer ☐ Stroke ☐ Heart attack ☐ Diabetes ☐ Depression ☐

Do you have any other chronic conditions?
What medications are you taking (including supplements)?

Do you smoke? Yes ☐ No ☐ If so, about how many packs per day?
Do you drink? Yes ☐ No ☐ If so, about how many drinks per day? Per week?
Please inform the doctor if you use any other recreational drugs.

Family History:

Have any members of your family had any of these conditions?
Breast cancer ☐ Ovarian cancer ☐ Colon cancer ☐ Thrombosis ☐ Pulmonary embolism ☐

Are there any known hereditary conditions in your family?

Obstetric History:

Provide information for each pregnancy and the name and location of the medical facility where the birth took place.

Year of your child's birth: Weight at birth: Method of delivery
unassisted ☐ C-Section ☐ Forceps / vacuum extractor ☐

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Have you ever had a tubal pregnancy? Provide dates for each episode and the name and location of the medical facility where the treatment was performed.

Have you ever had a miscarriage or abortion? Provide dates for each episode and the name and location of the medical facility where the treatment was performed.

What is the purpose of today's visit:

Pain ☐ Annual check-up ☐ Family-Planning ☐ Other:

How did you learn of us?

Referral from another physician (name/location)

Friends/Family ☐ Internet search engine ☐ Telephone directory ☐ Outdoor sign ☐
Other:

I completed this health history accurately to the best of my knowledge. If there were any questions that were unclear to me, I first asked the nurse receptionist or doctor for clarification before answering.

Patient's Signature, Date and Location

Thank you for your attention in completing your health history!

Dr. Stefan Buballa