Region Stockholm

Medical Form - gynaecology clinic

Date: _____ ID-number: _____

Name: _____

Height: _____ Weight: _____

Currently smoking:

Yes ◯ No ◯

Previous medical conditions:

_____

_____

Current medication:

_____

Allergies:

_____

No of pregnancies: _____ No of children: _____

No of vaginal deliveries: _____ No of caesarean sections:_____

No of miscarriages: _____ No of abortions: _____

Date of your last menstrual period: _____

Previous gynaecological surgery:_____

Current birth control:_____

Have your parents or sibblings been diagnosed with any of the following:

Breast cancer: ◯ Yes ◯ No

Blood clots: ◯ Yes ◯ No

Heart disease: ◯ Yes ◯ No