

## PATIENT HEALTH STATUS QUESTIONNAIRE

Patient's full name:
PESEL number: Date of birth*:
ID document type and number (if applicable):
Do you generally feel healthy?
YES □ NO □
Are you currently undergoing any treatment?
YES □ NO □
If yes, please specify:
Are you currently taking any medications?
YES □ NO □
If yes, which ones:
Are you allergic to anything?
YES □ NO □
If yes, please specify:
Do you smoke tobacco?
YES □ NO □
If yes, how much and since when:
GYNECOLOGICAL QUESTIONNAIRE
First menstruation
Age/year:
Self-initiated:
YES □ NO □
Induced by medication:
YES  NO



## Menstrual cycle

Cycle length (from first day of bleeding to first day of next bleeding):
Length of bleeding (days):
Are your cycles regular?
YES □ NO □
Bleeding is:
Heavy: YES □ NO □  Moderate: YES □ NO □  Light: YES □ NO □  With clots: YES □ NO □
Painful periods
YES □ NO □
Spotting between periods
YES □ NO □
Vaginal discharge
YES □ NO □
DELIVERY
YES □ NO □ Date:
Type of delivery
Vaginal:
YES □ NO □
Cesarean section:
YES □ NO □
MISCARRIAGE
YES □ NO □
Date: Week of pregnancy:
Spontaneous
YES □ NO □
Induced:
YES □ NO □



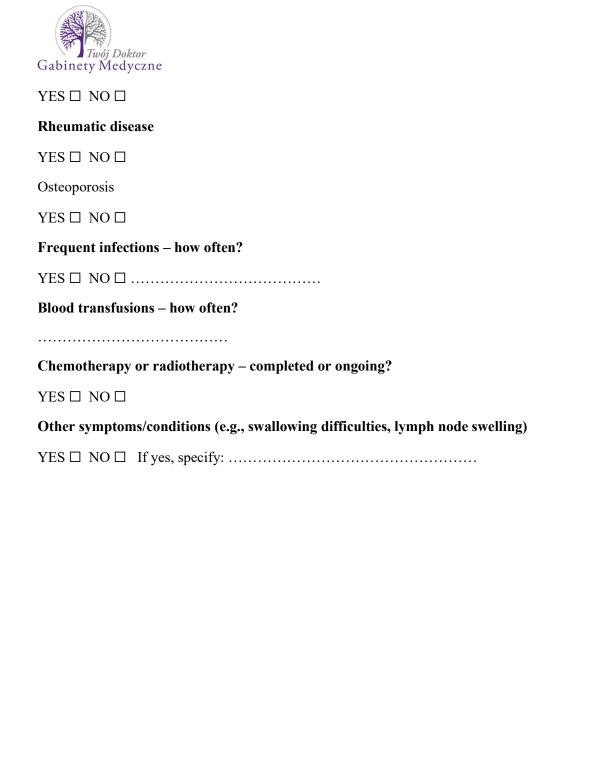
Gabinety Medyczne	
Tests	
Pap smear	
YES □ NO □ Date of last tes	t:
HPV test	
YES □ NO □ Date of last tes	t:
Breast ultrasound	
YES □ NO □ Date of last tes	t:
Mammography	
YES □ NO □ Date of last tes	t:
Oral hormonal contraception	
YES □ NO □	
Hormone replacement therapy	y
YES □ NO □	
Hormonal IUD (e.g., Mirena,	Kyleena, Jaydess)
YES □ NO □ Type and since	when:
Hormonal implant	
YES □ NO □ Type and since	when:
Non-hormonal IUD (e.g., IUD	, IUB)
YES □ NO □ Type and since	when:
Have you undergone gynecolo	gical procedures?
YES □ NO □ Date and type:	
GENERAL MEDICAL HIST	ORY
Have you ever had or do you s	suffer from:
Heart diseases (e.g., myocardi myocarditis)	al infarction, coronary artery disease, valve disease, arrhythmia,
YES □ NO □	
Other circulatory conditions (breath, fatigue)	e.g., hypertension, low blood pressure, fainting, shortness of

YES  $\square$  NO  $\square$ 



bruising, swelling, slow wound healing)
YES □ NO □
Blood disorders (if yes, specify):
YES □ NO □
Lung diseases (e.g., emphysema, pneumonia, respiratory failure, tuberculosis, asthma, chronic bronchitis)
YES □ NO □
Digestive diseases (e.g., stomach or duodenal ulcers, intestinal diseases, food intolerances)
YES □ NO □
Liver diseases (e.g., gallstones, hepatitis, cirrhosis)
YES □ NO □
Urinary tract diseases (e.g., kidney infections, stones, urination difficulties)
YES □ NO □
Thyroid disorders (e.g., hyperthyroidism, hypothyroidism, goiter, thyroid enlargement)
YES □ NO □
Neurological disorders (e.g., epilepsy, paresis, fainting, paralysis, sensory disorders, myasthenia)
YES □ NO □
Musculoskeletal disorders (e.g., back pain, spinal/joint degeneration, post-fracture conditions)
YES □ NO □
Blood and clotting disorders (e.g., hemophilia, anemia, bleeding tendencies, prolonged bleeding after dental extraction)
YES □ NO □
Eye diseases (e.g., glaucoma)
YES □ NO □
Allergies (e.g., asthma, drug reactions)
YES □ NO □
Mood disorders (e.g., depression, neurosis)
YES □ NO □
Infectious diseases (e.g., hepatitis A/B/C, tuberculosis)

Vascular diseases (e.g., varicose veins, phlebitis, poor circulation, leg pain, nosebleeds, easy



Signature of person collecting information

Date and legible signature of the patient