Twój Doktor
Gabinety Medyczne

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 ☐

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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 ☐

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Tests

Pap smear

YES ☐ NO ☐ Date of last test: ……..

HPV test

YES ☐ NO ☐ Date of last test: ……..

Breast ultrasound

YES ☐ NO ☐ Date of last test: ……..

Mammography

YES ☐ NO ☐ Date of last test: ……..

Oral hormonal contraception

YES ☐ NO ☐

Hormone replacement therapy

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 gynecological procedures?

YES ☐ NO ☐ Date and type: ……

GENERAL MEDICAL HISTORY

Have you ever had or do you suffer from:

Heart diseases (e.g., myocardial infarction, coronary artery disease, valve disease, arrhythmia, myocarditis)

YES ☐ NO ☐

Other circulatory conditions (e.g., hypertension, low blood pressure, fainting, shortness of breath, fatigue)

YES ☐ NO ☐

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

YES ☐ NO ☐

Rheumatic disease

YES ☐ NO ☐

Osteoporosis

YES ☐ NO ☐

Frequent infections – how often?

YES ☐ NO ☐ ……

Blood transfusions – how often?

……

Chemotherapy or radiotherapy – completed or ongoing?

YES ☐ NO ☐

Other symptoms/conditions (e.g., swallowing difficulties, lymph node swelling)

YES ☐ NO ☐ If yes, specify: ……

Signature of person collecting information

……

Date and legible signature of the patient

……