Dr Tiberius-Julius Dersidan
37, Route De Luxembourg
L-6450 Echternach
Tel: 00352-27993855
FAX: 00352-27998142
eMail: gynluxembourg@gmail.com
901406-82

Privacy Police

Please fill in your personal information :

Maiden name: _____

First name : _____

Family name (if married): _____

Matricule / date of birth : _____

insured with (mark with a cross): ☐ CNS ☐ andere Versicherung : _____

Address (street, number, post code, location) :

_____

_____

mobile phone: _____

fixed phone : _____

Email address : _____

1. I have been informed that my personal data will be stored digitally for the purpose of medical treatment in the practice of Dr. Dersidan. The data can and must be passed on to third parties such as laboratories, hospitals, treating physicians, tax offices and health insurance companies for the purpose of your treatment. Otherwise, the data will only be forwarded at your express request.

How can we contact you to inform you of the need for a new appointment or to inform you about your results ?

☐ By phone ☐ via mail ☐ via E-mail

_____

Date, signature

Dr Tiberius-Julius Dersidan

Dear patient,

The following data is of great importance for your treatment.
Please fill in all the points as far as you can and sign at the end of the document.

Name, first name : _____

Gynaecological history :

Date of last menstrual period : _____

Are you using contraception ? [] no

[] yes,: [] Pill, named :_____ [] Hormonal IUD [] Copper IUD

[] Vaginal ring [] condom

Do you smoke? [] no [] yes, about _____cigarettes per day [] stopped smoking since_____

Do you have any allergies against medicaments? [] no [] yes : _____

Have you already had gynaecological surgery?

[] no [] yes, what kind of surgery and when? _____

_____

Pregnancy:

Number of spontaneous deliveries : _____ **Number of caesarean sections :** _____

Complications at deliveries: _____

Number of miscarriages : _____ **Number of interruptions:** _____

Number of ectopic pregnancies : _____

General pre-existing conditions :

Have you knowingly had an infection with the human papilloma virus (HPV)?
(is examined in the screening smear test) ?

[] no [] yes

Have you been vaccinated against HPV ?

[] no [] yes

Do you have any other chronic diseases?

[] no [] yes, the following: _____

Medication:

Are you currently taking any medications on a regular basis?

[] non [] yes, the following : _____

When was your last gynecological examination : _____

Do you have any current complaints/problems, why you are coming today?

_____

_____

_____

Date, signature