TINES KLINIK
v/ Tine Tetzschner
speciallæge i gynækologi og obstetrik, Phd.

Welcome to Tines Clinic

Welcome to Tine Tetzschner and her team.

Before the first consultation, it would be helpfull if you could please fill in this form with various issues of significance to the consultation.

Personal information

Name			
Danish Security number			
Your height		Your weight	
E-mail		@	
Mobile phone			
Preferred form of contact		☐ E-mail ☐ Telephone	

Period etc.

Date of your last period		How often do you have your period?	
Do you bleed a lot?			
Number of pregnancies?		Number of abortions?	
Number of births?		Any c-section?	
Do you use birthcontrol?	☐ The pill ☐ IUD ☐ Condom ☐ Anything else		
Have you ever taken a cell test from the cervix?		If yes, when?	

Medicin

Name	Strenght	Daily dose

Former diseases in the abdomen

Disease:	When (Year)

Intoxicants

Alcohol, number of drinks per week	
Smoking, number of cigarettes per day	

Diseases

I suffer from following diseases	**N0**	**Yes**
Blood clots in the legs	☐	☐
Blood clots in the brain or heart	☐	☐
Asthma	☐	☐
Heart disease	☐	☐
Diabetes	☐	☐
Metabolism disease	☐	☐
Breast cancer	☐	☐
Hypertension	☐	☐
Osteoporosis	☐	☐
Other diseases – If yes, please indicate which disease:	☐	☐
Allergy – If yes, what are you allergic to?:	☐	☐

Is there in your close family (parents/siblings) any of the following diseases:	**No**	**Yes**
Blood clots in the legs, in a young age	☐	☐
Heart disease	☐	☐
Breast cancer	☐	☐
Diseases in the abdomen	☐	☐
Diabetes	☐	☐
Metabolism disease	☐	☐
Osteoporosis	☐	☐
Other diseases – If yes, please indicate which disease:	☐	☐

Hospital stay

Disorder	**Year**	**Treatment**