MVZ MCD GmbH
Betriebsstätte:
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Luise-Rainer-Str. 6-10
40235 Düsseldorf
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MVZ **M**edical **C**enter **D**üsseldorf GmbH

First Registration

Surname, First Name, Address, Phone Number, Mobile Phone Number, E-mail-Address:

_____

_____

_____

Do you have an allergy? Against which drugs/medicaments? _____

Which medicaments do you take regularly?

_____

Does your menstruation occur regularly? _____

Do you take hormones? If yes, please specify which? Do you have an IUD (Intrauterine device)?

_____

Do you have any kind of pre-existing disease (Diabetes, Hepatitis, HIV-Infection)?

_____

What is your current height and weight? _____

Have you ever had any kind of breast surgery? If yes, in which year and in which hospital?

_____

_____

Does anyone of your family have breast cancer?

_____

Do you have children?
If yes, how many? Did you have a normal delivery or a ceasarean section? Have you been breastfeeding your baby, and if yes, how long?

_____

Do you smoke? If yes, how many cigarettes in a day? _____
Do you have a private insurance for your stay in the hospital?
If yes, please specify the name: _____

Note: Please note that if you are due to have an operation, you can also have it performed in another breast center.

_____ _____
Date Signature