

BASIC DATA

Date*

Titel

Last name*

First name*

Date of birth*

Place of birth*

Insurance no.

Insurance company

Nationality*

E-mail*

Current address*

City/postcode*

Country*

(Mobile) phone*

Occupation

Employer

I am*

- ☐ married ☐ in a registered partnership
☐ in a partnership/cohabitation ☐ single

We are planning to be treated (date)

PARTNER

Titel

Last name*

First name*

BASIC DATA

How long have you and your present partner been trying to conceive?

Who is your gynaecologist?

How would you describe your cycle (period)?

☐ Regular ☐ Irregular

When did your last period start?

Have you ever been pregnant?

☐ Yes ☐ No

If yes: Did you experience any complications?

Do you have any children?

☐ Yes ☐ No

If yes: How many? (dates of birth)

If yes: Did you have a Caesarean section?

☐ Yes ☐ No

If yes: Were there any complications during birth?

What is your current weight and height?

<input type="text"/>	kg	<input type="text"/>	cm	BMI
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Did/do you smoke?

☐ Yes ☐ No

If yes: How many cigarettes a day?

Have you gained or lost a lot of weight in the last 12 months?

☐ No ☐ Gained weight ☐ Lost weight

Have you ever previously received any medical fertility treatment?

☐ Yes ☐ No

If yes: remarks

Have your fallopian tubes ever been tested for their patency?

☐ Yes ☐ No

If yes: remarks

Have you been diagnosed with endometriosis?

☐ Yes ☐ No

If yes: remarks

Was the endometriosis diagnosed and/or treated in the scope of an operation (laparoscopy, coelioscopy)?

☐ Yes ☐ No

If yes: remarks

Have you been diagnosed with ovarian cysts?

☐ Yes ☐ No

If yes: remarks

Have you been diagnosed with uterine anomalies?

☐ Yes ☐ No

If yes: remarks

Do you regularly take any medication?

☐ Yes ☐ No

If yes, name of the medication

BASIC DATA

Do you suffer or have you ever suffered from the following conditions?

Medication allergy ☐ Yes ☐ No

Against:

Thrombosis/Blood-clotting disorders ☐ Yes ☐ No

High blood pressure ☐ Yes ☐ No

Liver or kidney diseases ☐ Yes ☐ No

Neural diseases ☐ Yes ☐ No

Thyroid diseases ☐ Yes ☐ No

Infectious diseases (HIV, hepatitis, syphilis, etc.) ☐ Yes ☐ No

If yes: Which disease/s?

Other diseases:

When did you have your last PAP test?

Have you ever undergone chromosome testing (analysis of your blood for defects in your genetic material/genes)?

☐ Yes ☐ No

If yes: When?

If current, relevant results from other examinations are available, please bring them with you to the first appointment.

HOW DID YOU HEAR ABOUT OUR CLINIC?

A multiple choice is possible.

- ☐ Recommendation by gynaecologist
- ☐ Recommendation by friends/acquaintances
- ☐ Internet
- ☐ Social media
- ☐ Print media

Cancellation fees: The fee for the first consultation is EUR 150.00. You may cancel your binding registration via e-mail or phone. You may cancel your registration up to 24 hours before the first consultation free of charge. If you cancel at short notice (less than 24 hours before the first consultation) or fail to appear, 100% of the costs will be charged. Please return this completed medical history questionnaire immediately so that your first consultation can be fixed. Thank you!