



Personal information »couples wishing to conceive«

General information – woman

First and last name
 Street address
 Postal code and city
 Date of birth
 Profession
 E-Mail
 Telephone (day time)

General information – partner

First and last name
 Date of birth
 Profession
 Are you married **to one another**? Yes No
 When did you get married (date)?

Our questions for you

Your height Your weight Period / monthly cycle Every days and lasts days

How long have you been trying to conceive? (in years)

Have you already undergone fertility treatment? Yes No

Where, when and how?

Have you conceived **as a couple** in the past? Yes No

Please provide year: Births Miscarriages Terminations Ectopic pregnancies

Have you conceived **with another partner** in the past? Yes No Which one of you? My partner Me

Please provide year: Births Miscarriages Terminations Ectopic pregnancies

Do you have any allergies? Yes No List allergies here

Do you take medication? Yes No Please provide the exact name, strength and dosage

Do you suffer from a serious illness? Yes No List illness(es) here

Does your partner suffer from a serious illness? Yes No List illness(es) here

Have you had an operation in the past? Yes No Type of operation & year

Has the patency of the fallopian tubes been tested? Yes No
 When and what was the result?

Has a sperm analysis been completed? Yes No
 When and what was the result?

Have either you or your partner undergone a sterilisation procedure? Yes No
 When, and for which of you?

Has your partner had or do you have any fertility-limiting complications (e.g. undescended testis, testicular tumour)? Yes No
 When and which complications?

Do you have sufficient vaccine protection (twice) against measles and rubella? Yes No

Do you smoke? Yes No Cigarettes per day? Your partner? Yes No Cigarettes per day?

May we inform your doctor of your treatment reports in writing? Yes No