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)? .....
Date of appointment .....

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