kinderwunschzentrum
STUTTGART
PRAXIS VILLA HAAG
DR. MED. D.B. MAYER-EICHBERGER

MEDICAL HISTORY - FEMALE

Date: _____

Last name:	First name:	
Date of birth:	Maiden name:	City of birth:
Street, no.:	Zip code, city:	
Health insurance:	Profession:	
Tel. no.:	Cell phone no.:	
e-mail:	Nationality:	
Height:	Weight:	Married with this partner? yes ☐ no ☐
Do you smoke? yes ☐ how many a day: _____		no ☐
Do you drink alcohol? never ☐ rarely ☐ sometimes ☐ frequent ☐		

Your treating family doctor: _____

Your treating gynecologist: _____

Shall we send a report of the treatment(s) to your gynecologist? yes ☐ no ☐

Are you healthy: yes ☐ no ☐

If no, which illness do you have? _____

Remarks: _____

☐ Diabetes	☐ Thrombosis	☐ Asthma
☐ Epilepsy	☐ Thyroid dysfunction	☐ Gastro-intestinal disease
☐ Cardiovascular disease	☐ Nephropathy, adrenopathy, liver disease	
Carcinosis:		
Other diseases:		

Do you have to take drugs regularly? yes ☐ no ☐

If yes, which ones: _____

Did you already have a genetic counseling or chromosomal analysis before? yes ☐ no ☐

Result: _____

Did you already have a test for mucoviscidosis / cystic fibrosis before? yes ☐ no ☐

Result: _____

Did you already have operations? yes ☐ no ☐

If yes, which ones and when: _____

Name:	First name:

Test of tubal patency?: no ☐ yes ☐

If yes, when:_____ by which method: laparoscopy ☐ ultrasound ☐

Result: _____

Do you know of any allergies you have: no ☐ yes ☐

If yes, which ones: _____

Previous infertility treatments: no ☐ yes ☐

If yes, which ones:

Cycle monitoring and timed intercourse	no ☐	yes ☐	_____ no. cycles
Stimulation of ovaries with pills or injections	no ☐	yes ☐	_____ no. cycles
Insemination	no ☐	yes ☐	_____ no. cycles
IVF treatments	no ☐	yes ☐	_____ no. cycles
ICSI treatments	no ☐	yes ☐	_____ no. cycles
Cryo cycles	no ☐	yes ☐	_____ no. cycles

Previous pregnancies no ☐ yes ☐

Year: _____ result of pregnancy: _____ prev. partner ☐ current partner ☐

Year: _____ result of pregnancy: _____ prev. partner ☐ current partner ☐

Year: _____ result of pregnancy: _____ prev. partner ☐ current partner ☐

Last menstruation on (date): _____

Bleeding every _____ days Duration of bleeding _____ days

Pain during menstruation: no ☐ yes ☐

Mid-cycle bleeding: no ☐ yes ☐

Last appointment at your gynecologist's? _____

Unprotected sex since: _____

Problems when having sex? no ☐ yes ☐

Contraceptive pill? no ☐ yes ☐

If yes, when and how long: _____

Contraceptive coil (IUD) or injection? no ☐ yes ☐

Have you had yourself sterilized? no ☐ yes ☐

Have there been any of the following chronic diseases in your family,

e.g. siblings, parents or grandparents? no ☐ yes ☐

Cancer/other tumors _____

Genetic diseases _____

Cardiac or circulatory troubles _____

Others _____

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Name:	First name:

The examination of Anti-HIV-1,2, HBs-AG, Anti-HBc, Anti-HCV-Ab and, in few cases, of further parameters, is required by the German “Gemeinsamer Bundesausschuss” according to the guidelines on Assisted Reproduction following the specifications of the German Transplantation Act/Ordinance on tissues and organs (TPG-GewV) dated from July 16th, 2009 and August 21st, 2014.

In Annex 3 of the ordinance about the requirements for quality and security regarding the removal of tissues and their transplantation according to the German Transplantation Act is determined explicitly, which laboratory tests and methods of examination have to be performed necessarily.

I do agree that my blood will be analyzed regarding blood count, basic hormones and a possible infection with hepatitis and/or HIV. The latter two examinations have to be repeated every year.

I am aware that costs for these examinations may not be covered by my health insurance.

I do agree that my medical data and the results of my treatment(s) are reported to the German IVF Register (DIR) in an anonymous form for statistical purposes.

I do agree that if my bills will not be paid in time my personal data may be given to a lawyer or a collection agency.

I confirm the information given above to be true to the best of my knowledge.

Stuttgart, _____ _____

date signature